The UCL DClinPsy Training Handbook

Welcome to the Training Handbook for the Doctorate in Clinical Psychology (DClinPsy) at University College London!

The handbook is intended to help everyone involved with the Course, trainees, NHS supervisors, course staff, Experts by Experience and other members of our training community to find their way around the Course's structures and procedures.

The handbook provides information about the three main areas of competencies developed during clinical psychology training: clinical, academic and research. It ensures that the regulations which govern the DClinPsy are set out clearly and in a manner that is readily understood by all parties.

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Research Department of Clinical,
Educational and Health Psychology

Doctorate in Clinical Psychology
http://www.ucl.ac.uk/clinical-psychology

SECTION 1:

Doctoral Course in Clinical Psychology

Core Purpose, Values and Philosophy

Core purpose

The core purpose of the training course is to produce clinical psychologists trained to a high standard in academic, clinical and research domains, enabling them to meet the standards described by the HCPC Standards of Education and Training and Standards of Proficiency and the accreditation criteria of the British Psychological Society for Chartered status, and to qualify them for work within the National Health Service (NHS) and in other clinical settings.

Values

The values of the Course are aligned with those set out in the following codes, all of which can be found on the Course website:

- the HCPC Standards of Conduct
- the BPS Code of Ethics and Conduct
- UCL Student Disciplinary Code
- the NHS Constitution
- Health Education England's (2021) Position Paper on Aligning Clinical Psychology Training to the Priorities of the NHS Long-Term Plan

The values embodied in these codes are reflected at all stages and in all domains of the programme – in its application processes, in the content and delivery of the teaching programme, in clinical placements and in the professional and personal support offered to trainees.

The NHS constitution sets out some core values which can be summarised as follows:

- putting clients first and involving everyone who is relevant to their care
- speaking up in the client's interests when things go wrong
- affording respect and dignity to clients, their families and fellow professionals, valuing them as individuals and respecting their aspirations and commitments
- offering resources to the benefit of the whole community and ensuring that people are not excluded or discriminated against
- offering high-quality, safe and effective care
- offering care that is compassionate and responsive to the needs of clients, their families and carers
- improving health and well-being and people's experience of the NHS

Philosophy

1. The Course has a pluralistic ethos: it aims to expose trainees to a variety of approaches within clinical psychology rather than just one. This is designed to ensure that trainees can respond flexibly to the demands that will be made of them in a rapidly changing NHS.

2. The Course aims to promote strong links between theory and practice and is organised to ensure that the clinical, academic and research components of training are well integrated. Reflecting this concern:

> a) Diversity in teaching methods is encouraged, matching the method to the material to be taught.
> b) Skills teaching is integrated within the academic programme, along with the use of experiential teaching methods.
> c) Trainees are encouraged to adopt a hypothesis-testing approach to their work and to adopt a thoughtful and critical approach to the use of research evidence concerning the effectiveness of therapeutic techniques.

3. The Course endeavors to enable trainees to achieve high standards of clinical competence. To ensure high quality and relevance to the field, teaching is organised by a mixture of academic staff and clinical psychologist practitioners, many of whom have a national reputation in their fields.

4. The course aims to prepare trainees for systemic leadership, helping students develop a range of capacities that will enable them to drive service improvement in their clinical careers.

5. The Course aims to promote good practice in teaching and research across a wide range of specialties, and to ensure that teaching of specialities with recruitment difficulties is of the highest quality.

6. The Course tries to ensure that trainees can practice effectively and equitably in the context of the diversity that characterises clinical populations in London and the UK more widely. The promotion of equal opportunities in the selection of trainees and in teaching is an important feature of the Course philosophy, and a theme of the programme. Further, the development of our trainees' cultural competence is a crucial element of the programme, to foster their development as practitioners who can understand and help address cultural and social inequalities.

7. The Course aims to ensure that trainees develop a professional role that is both active and collegial, and hence a capacity to understand the roles and approaches of professional colleagues, and an ability to maintain good working relationships which promote the psychological well-being of clients.

8. The Course aims to foster an awareness of, and a responsiveness to, the needs of service users and carers, both through its teaching and by encouraging trainees routinely to consult with service users in order to understand their perspectives and needs.

9. As is consistent with the learner-led model of teaching appropriate for students at this level of training, the Course aims to be responsive to feedback at all levels of its organisation. The Course aims to ensure that its systems of assessment and evaluation of trainees also accord with best practice in this area and that trainees are involved in the assessment process.

10. The Course aims to foster an enthusiasm for learning and an openness to questioning, in teaching, in clinical practice and in research. Trainees are encouraged to follow up their interests and to develop personally over the three years of training.

11. The Course aims to make research an integral part of training by developing trainees’ capacity actively to make use of available research, and equipping them with the skills to contribute to the evidence-base of the profession. The Research Department of Clinical, Educational and Health Psychology has an internationally recognised research programme and trainees are encouraged to work with members of staff to maintain the same high standards for their own research

12. The Course aims to be responsive to its purchasers (Health Education North Central and East London) and to Clinical Psychology services in the London region who offer supervision to trainees and employment to graduates from the course.

14. It is widely recognised that clinical psychology training can be stressful and the course endeavours to ensure that good sources of support are available to trainees. As is consistent with the general course philosophy, no one approach is favoured, but rather a variety of systems (including access to personal therapy) are offered.

The standards set out above are those by which the Course wishes to be judged. The measure of our success is our capacity to enable trainees to develop personal and professional competences congruent with our aspirations, and to become effective practitioners who can apply their skills for the benefit of service users and carers and go on to shape clinical practice and research in the future.

SECTION 2: CLINICAL PSYCHOLOGY STAFF

Details of course staff, honorary staff, Associate Clinical Tutors, and regional unit organisers are on the course website.

SECTION 3: COMPUTING AND TEACHING RESOURCES

COMPUTING RESOURCES, LIBRARIES, ELECTRONIC RESOURCES, DCLINPSY LIBRARIES

COMPUTING FACILITIES

Extensive computing facilities are available in the "cluster rooms", of which there are many across the University campus, including one on the first floor of 1-19 Torrington Place (up the first set of stairs in the East lobby). Information about other locations can be found at: www.ucl.ac.uk/is/clusters/index.htm. Information about the "live" availability of PCs across campus can be found at UCL Go, a mobile app for student tasks https://www.ucl.ac.uk/isd/services/websites-apps/ucl-go

Computing facilities are managed by UCL rather than by the Department, and are accessed by students of all disciplines. Access can be limited, so it can be a good idea to book a computer in advance.

Training courses offered by Information Systems

UCL runs a number of introductory and advanced courses offered on-site and via e-learning. More information, is available at the UCL Information Systems website: www.ucl.ac.uk/isd/services/learning-teaching/it-training

LIBRARY RESOURCES

The UCL Library holds around 1.5 million volumes covering all subjects taught at UCL. About half of the stock is available on the open shelves. Holdings relevant to Clinical Psychology can be found at:

- DMS Watson library; also known as the Science Library (where most holdings can be found)
- UCL Medical School library (located in the medical school - Cruciform Building)

There is extensive information about the Library, its services, sites and opening hours at https://www.ucl.ac.uk/library/getting-started . The psychology subject librarian (Francine Wood) is available to help trainees with their literature searches for the thesis.

University of London Library (Senate House)

UCL students have access to the University Library (entrance on the fourth floor of Senate House, Malet Street). Tickets can be obtained by showing a UCL ID card. This library holds about 1.4 million volumes and over 5,500 current periodicals. The BPS library is based in Senate House, and holdings include a number of psychology journals unavailable in hard copy at UCL. The University of London library catalogue can be accessed via the UCL library website.

ELECTRONIC JOURNALS AND DATABASES

Journals

A very large number of journals can be accessed electronically, via the UCL library website. E-journals can be accessed from a UCL-managed computer (for example, a machine in one of the cluster rooms). They can also be accessed off-site (and therefore at home or on placement) using a UCL ID and password.

Databases

The library subscribes to a large number of on-line databases (including PsychInfo, Medline, and Embase) and citation databases. As above, these are available both on- and off-site.

COURSE MOODLE SITE

https://moodle.ucl.ac.uk/

The course uses Moodle as its platform for posting information about the academic programme. The site contains:

- details of upcoming lectures, including powerpoints, references and relevant resources
- teaching and training resources, including a suite of videos demonstrating CBT therapy competences

DCLINPSY TEST LIBRARY

Test Library

The psychological test reference library contains an extensive range of psychological tests, measures and questionnaires, providing invaluable tools for research, both for our trainees and for the wider UCL body. For Test Library enquiries, see the Research and Finance Administrator in the General Office.

Dissertation Collection

The dissertation collection (which includes dissertations of all past trainees) is available for trainee reference. Please visit the following link http://discovery.ucl.ac.uk/view/theses/ to access electronic version of thesis or contact the Library Services team at library@ucl.ac.uk; 020 7679 7792.

SECTION 4: COURSE COMMITTEES AND TRAINEE REPRESENTATION

COURSE COMMITTEE STRUCTURE

The Course needs to ensure that all its functions are carried out effectively, efficiently and appropriately. To achieve this each major aspect of the Course is managed by a committee. Most committees include representation from trainees, supervisors and psychologists working in the Region, and in many cases service users.

Committees and teams

Committees focus on particular areas of course activity (for example, selection procedures, the curriculum, clinical practice or research) but day-to-day work in each area is carried out by 'teams' of Course staff. It is the work of these teams that the committee oversees. The idea is that each committee identifies objectives and monitors the team, with the team being responsible for delivering these objectives.

An example of how this works will help. Membership of the selection committee includes the selection team, other members of the Course staff, trainee representatives, representatives of the Course's Experts by Experience committee, and psychologists from the region. The selection team is responsible for organising the selection process, but the committee checks that the team is doing this in an appropriate and effective way.

Though this might seem somewhat complicated, it ensures that the Course is managed openly and transparently, and that trainees and external representatives have a clear input into course procedures.

TRAINEE REPRESENTATION ON COMMITTEES

The course is a collaborative enterprise and trainees are involved in all aspects of planning and management. To help make this involvement as effective as possible, trainee representatives are invited to the following bodies:

- The Course Monitoring Committee (CMC) and Annual Course Review
- Sub-Committees of the CMC:
    - Clinical Practice Committee
    - Curriculum Committee
    - Research Committee
    - Selection Committee
    - Experts by Experience committee
    - Equality, Diversity and Inclusion (EDI) Committee
- The Staff-Student Consultative Committee

Election of Trainee Representatives

Each year group is asked to choose its own trainee representatives, and to inform the Course of these. Although trainee representatives should be elected each academic year (to ensure that these responsibilities do not become too onerous for any individual) individuals may stand for re-election.

COURSE COMMITTEES

COURSE MONITORING COMMITTEE (CMC) AND ITS SUBCOMIMTTEES

The Course Monitoring Committee (CMC) oversees the strategic direction of the Course. It is not concerned with day-to-day running of the Course but is more focused on how the course philosophy is executed and whether the content of training fits with the needs of the Region, the NHS and service users. For example:

- are we selecting and training the right sort of trainees?
- are we producing trainees with the right sort of clinical and personal/professional skills?
- how well are we meeting recruitment needs?
- are we teaching in the right sort of way?
- are placements set up in the right way?

Membership of the CMC brings together the ‘stakeholders’ who have a direct interest in the quality of training, and includes:

- Course staff
- Trainees
- Unit Organisers
- Supervisors and Clinical Psychology service leads
- Experts by Experience
- Representatives from the commissioners of training (North Central London LETB)

The meeting includes some reports from the Course, but the agenda is configured to ensure that issues which concern the various external 'stakeholders' are well-represented.

Frequency:	meets once a year
Experts by Experience representation:	at least one Expert by Experience
Trainee representation:	two from each year group
Trainee responsibilities:	to identify issues with their year group and to represent these at the committee

Annual Course Review

Each May the CMC meets to undertake the “Annual Course Review”. Its aim is to monitor the quality of the programme and overview the functioning of the Course in clinical, academic and research domains, to provide an opportunity for the course staff, trainees and stakeholders in the course to give feedback, for all parties to make suggestions for improvement, and to identify targets for change. Trainee representatives from each year group are required to provide a report summarising and feeding back their experience of training during the year and any particular issues raised.

CLINICAL PRACTICE COMMITTEE

This committee reviews the effectiveness of links between the course and clinical placements (for example, identification and allocation procedures, or support and training for supervisors). It is chaired by the Clinical Director, with membership including members of the tutor team, a further academic member of staff, a trainee representative from each year group, regional psychologists, a service user, the Course Administrator and the Clinical Placements Administrator.

Frequency: at least once a year, with additional meetings scheduled in relation to need
Experts by Experience representation: at least one Expert by Experience
Trainee representation: one from each year group

CURRICULUM COMMITTEE

This committee reviews the curriculum, and is chaired by the Academic Director. It is attended by teaching unit organisers (internal and external to UCL), a trainee representative from each year group, regional unit organisers and the Academic Administrator.

Frequency: at least twice a year, with additional meetings scheduled in relation to need
Trainee representation: one from each year group
Trainee responsibility: to identify curriculum-related issues with their year group and to represent these at the committee

RESEARCH COMMITTEE

This committee overviews issues relating to the research component of the course. It is chaired by the Joint Research Directors, and is attended by other staff involved in research supervision, the Course's Research & Finance Administrator, and a trainee representative from each year group.

Frequency:	twice a year (not meeting in second term)
Trainee representation:	one from each year group
Trainee responsibility:	to identify research-related issues with their year group and to represent these at the committee

SELECTION COMMITTEE

This committee reviews the effectiveness of selection procedures, and considers any necessary improvements and modifications. It is jointly chaired by the Selection Team Leader and the Senior Admissions Tutor, and attended by trainee representatives (usually from the third year), relevant course staff, regional psychologists and a representative from the Experts by Experience committee.

Frequency: twice a year, with additional meetings scheduled in relation to need
Experts by Experience representation: at least one Expert by Experience
Trainee representation: one third year trainee

EXPERTS BY EXPERIENCE COMMITTEE

The Experts by Experience committee aims to ensure that Experts by Experience (as well as past and current users of psychological services) can comment on and directly contribute to Course organisation, strategy and policy. It is facilitated by a member of the clinical tutor team and membership includes Experts by Experience, carers, course staff and a trainee representative.

Frequency: two – three times per year
Trainee representation: one-two trainees (from any year group)

EQUALITY, DIVERSITY AND INCLUSION (EDI) COMMITTEE

This is a new and developing committee. The EDI committee aims to provide a safe, formal structure within which to reflect on key issues relating to EDI across all aspects of training, to identify areas for development and improvement and to identify and review key actions and changes. Stakeholders, including trainees, Experts by Experience and course staff will help to shape the structure, function, focus and membership of the committee over time. The committee is chaired by the Course's EDI lead.

Frequency: Two to three times per year
Experts by Experience representation: at least one Expert by Experience
Trainee Representation: Three per cohort (two home fee and one international)
Trainee responsibility: To identify EDI-related issues within the year group and represent these within the committee

STAFF-STUDENT CONSULTATIVE COMMITTEE

This committee follows UCL standard practice and seeks to ensure student engagement and partnership and provides an opportunity for trainees to raise issues that affect the student experience but do not fit neatly within the focus of other committees. It is co-chaired by the Placement Co-ordinator and a trainee representative, with membership including course staff and trainee representatives from each cohort.

Frequency: once a term
Experts by Experience representation: none
Trainee representation: two from each year group

OTHER COURSE COMMITTEES

BOARD OF EXAMINERS

The overall aims of the Board of Examiners are to ensure that examination and assessment requirements of the Doctorate in Clinical Psychology are met in accordance with relevant University regulations. It reviews each trainee's progress in relation to all aspects of Course work.

Specific Duties

Oversee all Course assessment procedures including written examinations, course work and the clinical placements
Make recommendations for the appointment of external examiners
Appoint internal examiners
Liaise with external examiners
Oversee trainee progression and procedures in any instance of assessment failure
Report final results of all assessments to the University via the UCL Portico system
Agree policy and method for feedback on performance to trainees

Membership

Chair: Head of Research Department
Joint Course Directors
Academic and Clinical tutor staff on the Course
Internal and External examiners
September meeting is attended by a Brain Sciences Faculty observer to ensure procedures are in line with the University regulations

Frequency of meetings:	Twice a year: June/July, Interim Board (written examinations) September, Final Board (qualification and progression) (Additional meetings convened as required)
Experts by Experience representation:	none
Trainee representation:	none

COURSE EXECUTIVE

The Course Executive (which does not have the formal status of a committee) monitors the day to day running of the course and ensures the quality and effectiveness of course activities as a whole, overviews trainee progress in academic, clinical and research domains and (from time to time) makes proposals for improvements in the Course structure. The Executive is chaired by the Joint Course Directors, and is attended by the Academic, Research and Clinical Directors and the Course's Senior Administrator.

Frequency:	monthly, or as required
Experts by Experience representation:	none

Trainee representation: none

One function of the Course Executive is to act as an assessment team in order to review the operation of course assessment processes and to action recommendations from the Examination Board. It reviews trainee marks across all domains, reviews the rubric and functioning of all assessment procedures (including the rubric and content of examinations), considers course regulations and ensures these reflect requirements of internal and external regulators.

COURSE STAFF MEETING

This meeting (which does not have the formal status of a committee) ensures that staff views are appropriately represented within the course. It includes feedback of ideas developed by the Course Executive, and the standing agenda includes feedback from all the subcommittees of the CMC. In effect this is a forum for staff to raise and to discuss proposals affecting the course. It is chaired by the Joint Course Directors and is attended by all Course staff

Frequency: at least twice a term, with additional meetings scheduled in relation to need
Experts by Experience representation:
none Trainee representation: none

HOW THE COMMITTEES LINK TOGETHER

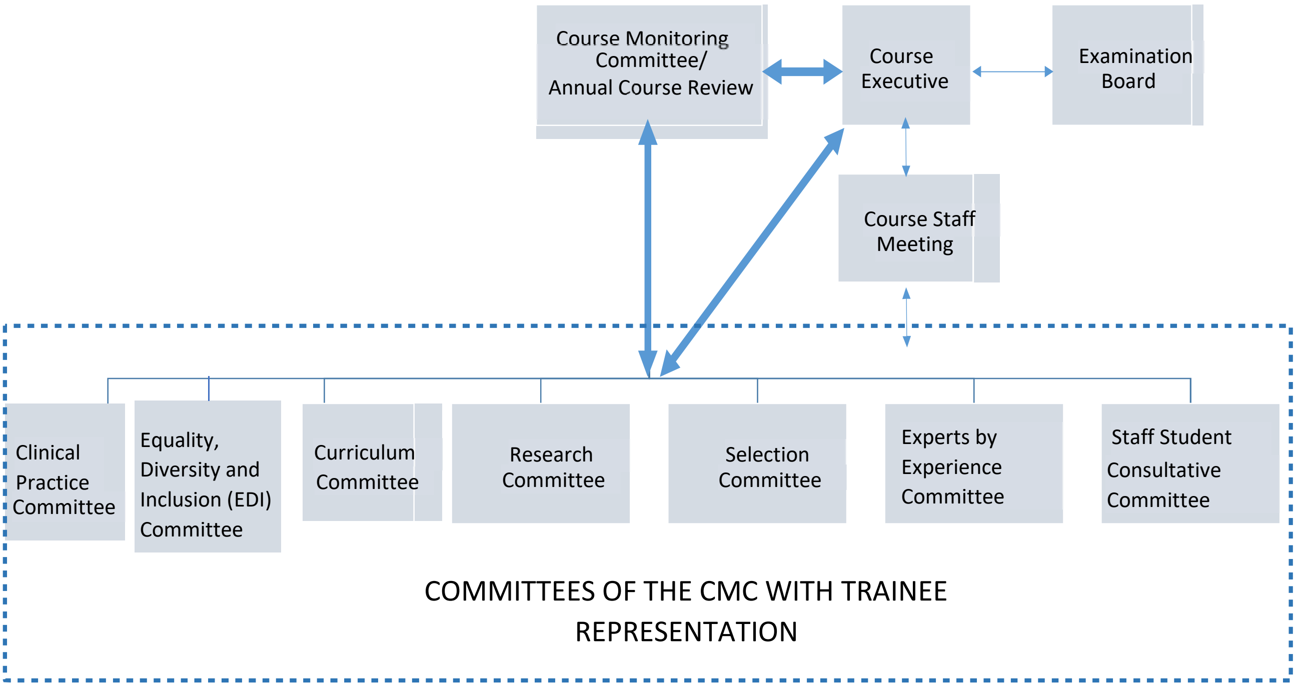
The organisational chart below shows how the various committees link together.

Essentially the Course Monitoring Committee (CMC) has oversight of all the 'working committees', all of whom report back to it, and all of whom take forward its decisions.

The Course Executive relates both to the CMC and the ACR (because it needs to ensure that any decisions made by the CMC including at its ACR are followed through) and to the working committees (because it needs to monitor the work of these committees and respond to any issues which they raise).

The Examination Board links to the course committee structure through the Course Executive.

UCL D.CLIN.PSY COMMITTEE STRUCTURE



SECTION 5: AIMS AND OBJECTIVES OF THE TEACHING PROGRAMME

The ultimate aim of postgraduate teaching is to foster and promote independent thinking, foster self-agency and ownership of one's learning and development whilst promoting a curious and respectful stance to learn with and from others. This will apply to all parts of the DClinPsy programme. Trainees are expected to participate actively in their own learning and to continue to develop their evaluative and critical faculties. They will be encouraged to assess and monitor their own learning to further their academic and professional development. Potential mechanisms to facilitate this include reflective seminars, contact with course tutors (through regular meetings, placement reviews and reviews of progress), professional development workshops, and trainee feedback to the course.

AIMS

All postgraduate programmes in the UCL Division of Psychology and Language Sciences aim to:

- educate students in systematic, scientific thinking about human beings and human problems;
- develop their ability and readiness to evaluate critically claims, theories and evidence in the human sciences;
- develop students' understanding of the impact of adversity on mental and physical health and psychological functioning;
- provide teaching that benefits from our position as a leading research department;
- encourage students to adopt leadership in directing their own learning and organising aspects of the curriculum.

OBJECTIVES

Students graduating from all postgraduate programmes in the UCL Division of Psychology and Language Sciences should:

- be able to communicate effectively in the professional or academic context for which they are being trained;
- be familiar with the methods of quantitative and/or qualitative data analysis used in their area of study;
- be able to locate, understand, evaluate and apply current research in their area of study;
- have gained skills in conducting a research project relevant to their professional goals, from planning to execution, analysis and report;
- have developed an awareness of professional, ethical and social issues relevant to professional practice for which they are being trained, and the institutional context in which this practice takes place;
- be able to reflect on their own and others' work and show leadership in taking forward insights and developments likely to benefit service users.

The Doctorate in Clinical Psychology aims to enable trainees to develop the academic, clinical and research skills needed to prepare them for practice as professional Clinical Psychologists, eligible to apply to the Health and Care Professions Council for registration as a Clinical Psychologist. On this basis, the programme aims:

1. To train candidates to be able to work as clinical psychologists with a wide range of clients and services in a range of settings having high priority within the NHS and other areas of public health provision. Upon qualification trainees should be committed to the core values of the profession including the reduction of psychological distress and enhancing and promoting psychological well-being through the systematic application of psychological theory and evidence. Trainees will be committed to the view that all people have the same human value and the right to be treated as unique individuals and to anti-discriminatory practice.

2. To develop the skills, knowledge and values to form working alliances with individuals, carers and services. To carry out psychological assessment, formulation and interventions grounded in the best available psychological theories and evidence. To develop effective communication and professional skills to work with a variety of professionals, systems and non-specialists. Trainees will be able to demonstrate awareness and values reflecting an understanding of difference and diversity and the impact of adversity, and to work effectively, both directly and indirectly, with systems relevant to service users, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.

3. To empower trainees to undertake original research that makes a scientific contribution through the collection of new knowledge. To promote an appreciation of the role of systematic research in the monitoring and improvement of clinical services in all areas of healthcare, as well as the contribution of more exploratory and qualitative approaches. To recognise the importance of working in partnership with experts by experience. To appreciate the importance of the profession continuing to develop its knowledge base; to monitor and improve the effectiveness of its work; to manage a personal learning agenda throughout one’s career, including consideration of self-care; demonstrating critical reflection and self-awareness that promotes standards of practice and the transfer of knowledge and skills to new settings and problems.

SECTION 6: THE TEACHING PROGRAMME

Trainees start with a full-time, four week long block of teaching. This consists of an initial induction to give trainees a chance to get to know the course and each other and find their way around UCL and the course. Thereafter trainees receive an introduction to key ideas and skills that form the foundation of clinical psychology theory and practice, before they start their placements in week 5. After this, teaching takes place on two days a week during academic terms.

Teaching aims to prepare trainees for their professional work as clinical psychologists in training. There is a developmental sequence of teaching which aims to reflect the basic tenets of the course philosophy:

- to help trainees link theory to practice, such that they understand the principles and models which underpin their work, and hence are better able to apply their knowledge and skills to novel clinical situations and across clinical areas
- to help trainees develop critical thinking skills, based in a sound understanding of the theory and evidence of academic psychology, so that they can operate flexibly and creatively in their work and contribute to professional innovation
- to help trainees understand the principles underpinning psychological interventions as well as ensuring that they have the skills to undertake them
- to develop trainees' understanding of the evidence-base relating to clinical psychology, such that they are aware of evidence and the manner in which it is obtained, understand its limitations and are able to bridge any gaps in available research
- reflecting the course's pluralistic ethos, trainees are encouraged to develop an understanding of and respect for the major schools of psychological therapy
- in line with BPS accreditation criteria, we aim to enable all trainees to achieve competence in two evidence-based models, one of which must be cognitive behaviour therapy, the other will be psychodynamic or systemic therapy (of note, all trainees receive teaching on all three models)
- to support trainees' personal and professional development and their capacity to become reflective practitioners who can function in diverse clinical contexts
- to support trainees in becoming culturally competent practitioners who are sensitive of diverse cultural and social contexts and their impact on psychological functioning, understand the role of adversity and trauma in the development and maintenance of mental health difficulties, and able to address such issues in relation to access, engagement, and service delivery more broadly
- to develop trainees' understanding of fundamental ethical principles and standards and how to ensure these are adhered to in all areas of their work
- to develop trainees' ability to work in partnership with service users, family members and formal carers, experts by experience, and members of other professions and organisations, and a recognition of the value of working in partnership with these groups in the design and delivery of services
- ensure trainees have a strong value base that fits closely with NHS values

Full details of the current academic programme are available on the Course web site. These are shared with supervisors at the start of the placement, to ensure that they know what is being taught at college.

We try to match academic input to placement experience. This is easier at the start of the course, since almost all trainees start with placements which expose them to adults with mental health problems. After this each trainee will follow a different placement order, which creates more of a challenge to the link between teaching and practice. As such, trainees are expected to actively shape their own learning right from the start, through reading and an active participation in supervision, in order to meet the demands of their placement context.

The teaching programme consists of several modules that reflect the various academic and clinical aims of the course. These take place in parallel and are timed to reflect a developmental progression in trainees' knowledge and skill base and their accumulating clinical experience. As such, the first two terms focus on key scientific and clinical principles and central skills for assessment, engagement, intervention and research. In addition, specific therapeutic models are introduced that are particularly relevant to working with adults in order to meet the demands of trainees' first placements. Teaching on research methods begins in term 2 of the first year. In the third term of the first year and the first term of the second year, the teaching programme considers lifespan developmental processes and this teaching coincides with clinical skills teaching on systemic therapy. Alongside this lifespan perspective, practice-focused teaching in these terms examines psychological work with children, adolescents, adults and older adults in a developmental sequence. The rest of the second year then focuses on disability and health and forensic psychology, and again marries academic teaching with related clinical skills teaching, practice-related teaching and professional issues. Statistics teaching is provided in Term 2 of the second year.

There is a reduced schedule of teaching in the third year with trainees attending teaching one day per fortnight to allow time for research. The aim of the teaching in the third year is to introduce advanced issues in clinical psychology science and practice. This includes attention to more integrative therapies and new developments in theory and research as well as a consideration of important professional issues designed to smooth the way into qualified professional practice. Furthermore, in the months following submission of the thesis trainees take responsibility for the organisation of the teaching programme.

CONTENT OF THE ACADEMIC PROGRAMME

The teaching programme is organised along what are known as 'core competency' lines. What this means is that the programme has been designed to reflect what are generally agreed to be skills and knowledge that clinical psychologists should possess and able to apply across a range of client groups. Our belief is that focusing on the knowledge base of psychology as an academic discipline and bringing together and synthesising clinical expertise and experience from a variety of disciplines is key to achieving this aim.

The curriculum is organised around these ideas and consists of six core modules:

1. Theoretical underpinnings and diverse clinical settings
2. Assessment and Formulation
3. Interventions
4. Professional Issues and Cultural Competence
5. Research
6. Seminars, Masterclasses and Conferences

The content of each of these modules is fairly self-evident. The Academic Psychology Module represents teaching on the academic knowledge base relevant to clinical psychologists. The Assessment and Formulation Module teaches the theory, knowledge and skills required to conduct informative, sensitive, appropriate and individually tailored psychological assessments and to use psychological theory and models to conceptualise clinical material in a way that organises clinical thinking and interventions. The Interventions Module aims to give trainees a solid grounding in philosophy, models and skills associated with four major schools of psychological therapy – behaviour therapy, cognitive behavioural therapy (CBT), psychodynamic psychotherapy, and systemic therapy. In addition, the module provides training in a range of core clinical skills that are common to all schools of therapy (such as the skills required to develop a working alliance). The Professional Issues Module provides teaching on a wide range of issues relevant to professional practice, including issues of conduct and ethics, relevant legal frameworks and government initiatives that shape the context of services nationally. Especially important in this module is the consideration of issues of cultural competence and difference and diversity as they affect trainees' critical understanding of theory and work as a clinical psychologist. The Research Module provides in-depth training in research methods and statistics and forms the backbone and support for the development of trainees' major research project. Finally, the Active Learning Module is designed to allow trainees greater opportunity to reflect and debate key clinical and academic issues in clinical psychology, draw links between disparate components of academic clinical psychology and use their critical skills in a collegial, discursive environment with the guidance of clinical and academic members of staff and experts in the field. The module also focuses explicitly on trainees' personal and professional development and encourages their development as reflective practitioners through regular seminars.

Each module is usually coordinated by one or two convenors. In many cases one will be an internal convenor from the course, the other(s) a psychologist(s) from the region who has expertise and experience in the relevant area, and can represent the relevant BPS Faculty or Special Interest Group. There is close coordination within and across units, which aims to minimise overlap and repetition, and to ensure that the curriculum aims are met.

The curriculum is currently organised in the following way:

Initial Teaching Block

During the first month of training, trainees are full-time at college. This starts with an induction to the programme, which is deliberately low-key. During the induction trainees meet members of staff, learn about the programme, have plenty of time to get to know each other, meet with second year trainees, and learn about key procedures and services within UCL and Camden and Islington NHS Foundation Trust as their employing authority.

During the remainder of the initial teaching block, trainees learn core clinical skills, receive lectures that provide overviews of some key theories and theoretical aspects that are pertinent to clinical psychology, and are introduced to all the main therapy models. This teaching introduces trainees to many of the modules outlined below, which then continue throughout the Course.

Module: Theoretical underpinnings and diverse clinical settings

The course has adopted a **biopsychosocial** and **developmental psychopathology** framework as overarching means to understanding psychological difficulties. Developmental psychology offers a broad, integrative framework that can take account of a wide range of theories, as well as biopsychosocial factors. As such we use a life span approach to thinking with trainees about the many factors that can contribute to the development of psychological difficulties or in turn increase individuals' resilience.

Units

Central Themes in Clinical Psychology

The aim of this unit is to provide the conceptual background to training as a clinical psychologist in the NHS. This involves familiarity with major theoretical frameworks in current use by clinical psychologists working in the field. Each of these approaches will be covered only briefly highlighting critical epistemological assumptions, broad explanatory frameworks for both normality and psychopathology, the evidence base of key tenets of the particular perspective and the investigative and clinical methods that are associated with these points of view.

Key Presenting Difficulties

The aim of this unit is to outline major psychological disorders and difficulties, critically examine theories relating to their aetiology and outline the conceptualisation of mechanisms of development, maintenance and change. (Where the evidence indicates that certain psychological problems are most appropriately conceptualised from a CBT model, they will be covered as part of the CBT unit of the interventions module.) Subunits on Psychosis, Neuropsychology and Forensics consider theory and its application in clinical practice in relation to these clinical presentations and settings.

Lifespan Development

This unit focuses in detail on development across the lifespan, by considering processes of continuity and change, normal and atypical developmental pathways, factors affecting the negotiation of critical developmental tasks and the inter-connections between developmental changes in cognitive, emotional and social capacities and the environments in which these are embedded. The unit examines typical social and cognitive development in childhood and adolescence, common psychological difficulties of this developmental period, the role of parenting and attachment in socio-emotional development, and the transitions to school, adolescence, adulthood, parenthood, mid-life and older age. The unit considers the changing patterns of social relationships across the lifespan and issues and problems that are particularly prominent at different developmental stages. Consideration is given to developmental changes associated with ageing in later life, to shifting social expectations and attitudes associated with different stages of the lifespan and the impact of changes in social relationships across the lifespan, such as loss and bereavement.

Health and Disability

This unit covers in detail various manifestations of human disability, including intellectual disability, physical disability and chronic illness, and pertinent issues which are relevant to clinical psychology theory and practice. The impact of underlying impairments and illness as well as societal barriers on psychosocial functioning are considered. Psychological perspectives on health will be introduced within a clinical health psychology framework, with an emphasis on the two-way relationship between physical health and psychological processes. An overview of the main theories, concepts and issues in clinical health psychology is provided, and health psychology approaches to managing illness and disability, and health promotion, are discussed. Psychological approaches to intellectual disability are considered within the broader social context and in relation to the numerous barriers to good quality of life for individuals with intellectual disabilities.

Module: Assessment and Formulation

The aim of this module is to equip trainees with core clinical skills, to develop their understanding of the role of clinical formulations in treatment planning and enable them to perform a wide range of psychological assessments. The module is concerned with ensuring that trainees can psychologically assess and formulate across a wide range of clinical settings and client groups. At the end of the module trainees will have knowledge pertaining to the assumptions, uses and limitations of different assessment methods and how these relate to the development and evaluation of clinical formulations. Trainees have ample opportunity to practice these skills. A key aim of this unit is to integrate teaching of theory and skills required to competently undertake psychological assessment and develop formulations.

Module: Interventions

The aim of this module is to introduce trainees to commonly used and innovative models of intervention practised in the NHS. For each model of intervention, the rationale is introduced, the basic skills and techniques are described and practised, and the evidence base for efficacy and effectiveness is examined. Their application for different presenting problems, populations, and stages of the lifespan are discussed and limitations of each model examined.

The Interventions Module has five units:

1. Behaviour Therapy
2. Cognitive Behavioural Therapy
3. Psychodynamic Psychotherapy
5. Systemic therapy
6. Advanced/integrative therapies

In line with the BPS accreditation criteria, the module aims to enable trainees to achieve competence in two evidence-based models, one of which must be CBT, the other psychodynamic or systemic therapy. This is achieved through a combination of teaching on theory and its clinical application in the different approaches, small group supervision in CBT across years 1 and 2, and seminars in psychodynamic and systemic therapy in year 2.

Module: Professional Issues and Cultural Competence

The Professional Issues and Leadership unit equips trainees with knowledge and skills relevant to professional practice, and covers a wide range of topics, such as evidence-based practice and practice-based evidence, clinical governance ethics, leadership models, leadership in practice, communicating with other professionals and the public, and working in partnership with experts by experience.

The Cultural Competence unit, in recognition of the vast importance of issues relating to cultural identity/identities in our everyday lives and clinical practice, provides a space where such issues are explicitly addressed and reflected upon. The unit consists of two introductory sessions, and a range of “spotlight” sessions.

Module: Research

The aim of this module is to give trainees the knowledge, skills and confidence to carry out research, evaluation, and audit studies. In this module trainees become familiar with the fundamental methods and concepts of clinical psychology research, including qualitative and quantitative methods, small N designs, audit and evaluation methods. Trainees develop their skills in reading and appraising published research studies. They will have acquired a grounding in the main methods of statistical analysis, and be able to use the SPSS/JASP statistical package to carry them out.

Through the completion of both a service evaluation project and a major piece of rigorous scientific investigation, trainees gain experience of the scientific method through the stages of planning, execution, analysis, presentation and dissemination.

Module: Seminars, Masterclasses and Conferences

The active learning module allows trainees greater opportunity to reflect and debate key clinical and academic issues in clinical psychology, draw links between disparate components of academic clinical psychology and use their critical skills in a collegial, discursive environment with the guidance of members of staff and experts in the field. The module has five core components:

1. Clinical seminars
2. Reflective Practice Seminars
3. Social GGRRAAACCEEESSS Seminars
4. Masterclasses
5. Conferences

Clinical seminars
These seminars have been an important part of the teaching programme for many years. Trainees attend two seminars per term, and take turns in presenting cases from their clinical placement. These cases are then formulated in detail using different theoretical models, and the group discusses pertinent clinical and theoretical issues that arise. The seminars are each facilitated by two experienced clinical psychologists, and the emphasis is on integration of theory and practice. Trainees are encouraged to think creatively within and across theoretical orientations, and are able to raise clinical dilemmas and problems in an atmosphere of free discussion.

Reflective Practice Seminars
These seminars emphasise the importance of reflective practice as an integral part of trainees' development. Trainees attend monthly seminars and within their group consider the impact of clinical scenarios from their placement focused on a specific theme for each seminar. The seminars are part of a much broader approach to supporting trainees' personal and professional development through all aspects of training and use Kurtz et al.'s (2020) Heads and Hearts model of reflective practice. Trainees are expected to bring clinical and/or personal-professional material to each seminar. The seminars are a mix of staff-facilitated and trainee-led.

Social GGRRAAACCEEESSS Seminars

These seminars provide trainees with an opportunity to critically reflect upon social realities indelible to the self, with the broader aim of supporting the journey of cultural humility practice and personal-professional development. They use the frame of 'Social Graces' (developed by Burnham and colleagues), which represent aspects of difference in beliefs, power and lifestyle, visible and invisible, voiced and unvoiced, to which we might pay attention. This framework provides an aid to assess one's relationship with the different aspects of the Social Graces, in both personal lives and whilst on clinical training. In particular, it allows for one to explore the influence of the Social Graces on us and our 'practice/profession'; many of which could have a dominant presence or, alternatively, may be invisible or unnoticed.

Masterclasses

These take place towards the end of the autumn and spring terms, and are attended by all three trainee cohorts. They are designed to expose trainees to advanced conceptualisations of clinical material from a range of perspectives. The usual format is a detailed case presentation by a third year trainee, followed by formulation and thoughts for intervention by three "experts" representing different therapeutic schools, theoretical orientations or disciplines.

Conferences

The conference programme covers a wide range of clinical areas and aims to present innovative developments and debates relevant to clinical psychology. National and international experts are invited to debate critical dilemmas and engage trainees in a discussion of the cutting edge of clinical psychology science and practice. Conferences bring all year groups together and are open to all regional supervisors, numbers permitting.

THIRD YEAR TEACHING

The third-year teaching programme aims to cover advanced topics in the different therapeutic approaches, to provide teaching relating to leadership skills and the role of clinical psychologists beyond a clinical role in greater depth, and to prepare trainees for their first jobs post-qualification. Following submission of the thesis in June of Year 3, trainees organise the final teaching block in September of year 3 with support from the Course.

TRAINEE FEEDBACK ON TEACHING

Trainee feedback is very important to us. It helps us to evaluate our teaching programme, to address any problems as they arise, and to make improvements where necessary for future programme planning. It also encourages us to hear when we have got it right!

Feedback is collected electronically via Moodle. For most teaching units, feedback is gathered after every lecture. However, for seminar series and for units that are taught by the same lecturer and form an integrated whole, feedback is sought at regular time points rather than after each session. Feedback is shared with the speaker, the unit organizer and the Academic Programme Team ('Team Teach'). Team Teach also have a monthly slot open to trainee curriculum representatives to feed back any issues for rapid action and a summary of actions taken in response to trainee feedback is provided on a termly basis.

Teaching issues and trainee feedback are discussed in the Curriculum Committee (CCM) and at the Annual Course Review. Team Teach have a collaborative relationship with trainee curriculum representatives who attend the termly CCM and also meet with Team Teach at the start of the academic year and ahead of each CCM.

SECTION 7: PLACEMENT SCHEDULE

CLINICAL STUDY TIME
PATTERN OF DAYS IN COLLEGE AND ON PLACEMENT
MINIMUM NUMBER OF DAYS ON PLACEMENT

Although the basic pattern of days in college and days on placement is fairly straightforward (and is set out below) supervisors and trainees need to be aware that clinical study time and research study need to be factored in. The tables below should make this clearer, but some explanation of how clinical and research study time fits into placement time is needed first.

Clinically-related study on placement

Clinical study time allows trainees to read up about clinical work they are undertaking - for example, to read about tests they are using, or about theories or models which relate to clients they are seeing.

Trainees are entitled to the ***equivalent*** of half a day's clinical study time while on placement. This allows them to read-up on clinical issues related to their clinical work. The time works out at about one hour for each day on placement – up to a maximum of three hours a week.

The critical word in the specification above is "equivalent". Study time could be taken as a half-day, but in many settings this may not be the most efficient use of time, and the rule of thumb is that the time should be taken in the way which best suits the trainee and the supervisor. It can be taken as a "block" of time, but also (for example) at the rate of one hour a day. Whatever way it is taken, this should be negotiated at the start of the placement and interpreted flexibly in relation to need – there may be some variation from week to week. For example, while in some weeks there may be a lot of reading to do, at other times there may be little, and it would be better to spend more time on clinical activities.

Bear in mind that:

a) Study time is not leave. It cannot be carried over from one week to the next, or added into annual leave

b) It is 'earned' by virtue of being on placement. This means that when the trainee is on placement fewer than three clinical days, the amount of clinical study time decreases proportionately. It follows that in weeks where the trainee is absent from the placement, there is no entitlement to study time

At two points in the training cycle (in the academic holidays of the first year and in the summer of the third year) trainees can be on placement for four days a week. The fifth day is a full day of study. As such clinical study time need not be taken while on placement, and trainees can work four full clinical days. The tables below make this clearer.

PATTERN OF DAYS IN COLLEGE AND DAYS ON PLACEMENT

Pattern during academic terms
During academic terms trainees spend either two days or one day a week in college, as follows:

Year 1

Monday	Tuesday	Wednesday	Thursday	Friday
placement	college	Placement	college	placement

Year 2

Monday	Tuesday	Wednesday	Thursday	Friday
placement	placement	College	placement	college

Year 3

Monday	Tuesday	Wednesday	Thursday	Friday
Trainees are on placement three days a week, with two days for research or attendance at college. College days are always on Friday. This means that supervisors and trainees are free to discuss which day is taken for research.				college

Pattern outside academic terms
Out of academic terms trainees are sometimes available to work an extra clinical day on placement, but this depends on their year of training. As the pattern can be a little complicated it is best is explained using the following tables:

Year 1	**No of days per week spent on placement**	**clinical study time**
Term 1 (usually late September - mid-December)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Christmas holiday	4	see footnote a
Term 2 (usually mid-January – late March)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Easter holiday	4	see footnote a
Term 3 (usually late April – early July)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Summer holiday	4	see footnote a

a) During holiday periods Year 1 trainees are on placement for 4 days a week. The fifth day is a full day of study. As such “clinical study on placement” is subsumed into the study day, and trainees can work 4 full clinical days. Because there are no college days, supervisors and trainees can take advantage of flexibility about which days of the week trainees come to placement, and which day is taken for study

Year 2	**No of days per week spent on placement**	**clinical study time**
Term 1 (usually late September – mid-December)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Christmas holiday	3	see footnote b
Term 2 (usually mid-January – late March)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Easter holiday	3	see footnote b
Term 3 (usually late April - early July)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Summer holiday	3	see footnote b

b) During holiday periods Year 2 trainees are undertaking research, and have one day for study time and one day for research. "Clinical study time on placement" is subsumed into the two study days. This means that trainees will be working 3 full clinical days.

Year 3	**No of days per week spent on placement**	**clinical study time**
Term 1 (usually late September – mid-December)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Christmas holiday	3	see footnote c
Term 2 (usually mid-January – late March)	3	trainees should have the equivalent of 0.5 days per week study time during these 3 clinical days
Easter holiday	3	see footnote c
Term 3 – up to the point thesis is handed in (usually late June))	3	see footnote c
Summer holiday	4	see footnote d

c) During Christmas and Easter holidays, "clinical study time on placement" is subsumed into the two study days. This means trainees will be working 3 full clinical days.

d) After the thesis is handed in, trainees can work 4 clinical days, with the fifth day being for study. The exception to this is when a trainee has formally requested (from both college *and* the placement supervisor) time to write-up their research for publication in a journal. If permission is forthcoming, they can have an additional study day to undertake this work (i.e. making two study days a week).

MINIMUM NUMBER OF DAYS ON PLACEMENT

- The BPS specifies that at least 50% of a trainee's time on the Course is spent on placement.
- This requirement is not specified in terms of an expected number of days in each placement, but in practice this means that a trainee needs to accrue between 60 and 65 clinical days in any one six-month placement period.
- On some placements the number of days may drop slightly below this number – for example if a trainee is ill, or if there are other unforeseen circumstances.
- Trainees who anticipate accruing less than 60 days in a placement should discuss this with their Course Tutor. Trainees should not have less than 55 days on a placement.

SECTION 8: CLINICAL PLACEMENT GUIDELINES AND PLACEMENT CONTRACTS

AN OVERVIEW OF THE CLINICAL COMPETENCES TRAINEES NEED TO ACQUIRE DURING TRAINING

By design the range and content of clinical placements reflects the criteria set out by the Health and Care Professions Council for registration as a Clinical Psychologist, and by the BPS for Chartering as a Clinical Psychologist. The former are set out in the 'standards of proficiency' for practitioner Psychologists which can be found here and the latter in the accreditation criteria for clinical courses which are updated reasonably frequently. The most up to date version can be found on this website.

In practice there is considerable overlap between these criteria, and what follows is an outline of the competences trainees need to acquire over the course of training, along with an indication of the client groups with whom they need to work, the clinical contexts in which they see these clients, and the clinical approaches which they need to apply.

As should be clear from the preceding paragraph, it is misleading to think of training pathways as linking only with competences – these are important, but just as critical is the need for trainees to operate in and with a broad range of clinical and organisational contexts and to be acquainted with a variety of psychological approaches.

The diagram below is a schematic representation of the criteria – by no accident it is the basis for the trainee's 'cumulative training record, which helps to identify progression through training.

The far left hand column sets out a set of 'transferable competences', and the columns to the right the clinical contexts, clinical populations and clinical approaches with whom these competences need to be demonstrated. The 'transferable skills' are those identified as a core set of competences for the profession, employed in almost all interventions and contexts. They are described as transferable not only because they are employed so ubiquitously, but also because with repeated application they are employed in an increasingly sophisticated manner. For this reason they are sometimes referred to as "iterative" skills.

The variety of contexts, populations and approaches required of trainees is quite broad, and is intended to develop a capacity to employ a wide repertoire of skills in a range of increasingly complex situations. One hallmark of training should be the acquisition not only of specific skills, but also a capacity to problem-solve and to apply these skills when faced with novel clinical problems, and to both identify and implement appropriate solutions.

The criteria mean that there is no single pathway through training, since the competence standards can be met in a range of clinical contexts. This having been said, there is some consistency in the 'shape' of training – for example, trainees need to work with individuals across the lifespan, and this means that they will have placements which give them experience of work with adults with mental health problems, with children and adolescents and with older adults.

Some of the diversity in training pathways is accounted for by the fact that the criteria do not mandate any specific service settings. A good example is the requirement for trainees to work with people with a range of intellectual functioning. This does not mean that all trainees need to work in a service for people with learning disabilities. The criteria identify core *populations* rather than core *placements*; and although in practice these can be coterminous with service settings, this is not always the case. Clearly, work in a child development unit will give trainees experience of work with children with learning disabilities, even though the service itself is 'labelled' as a child (rather than as a learning disability) service.

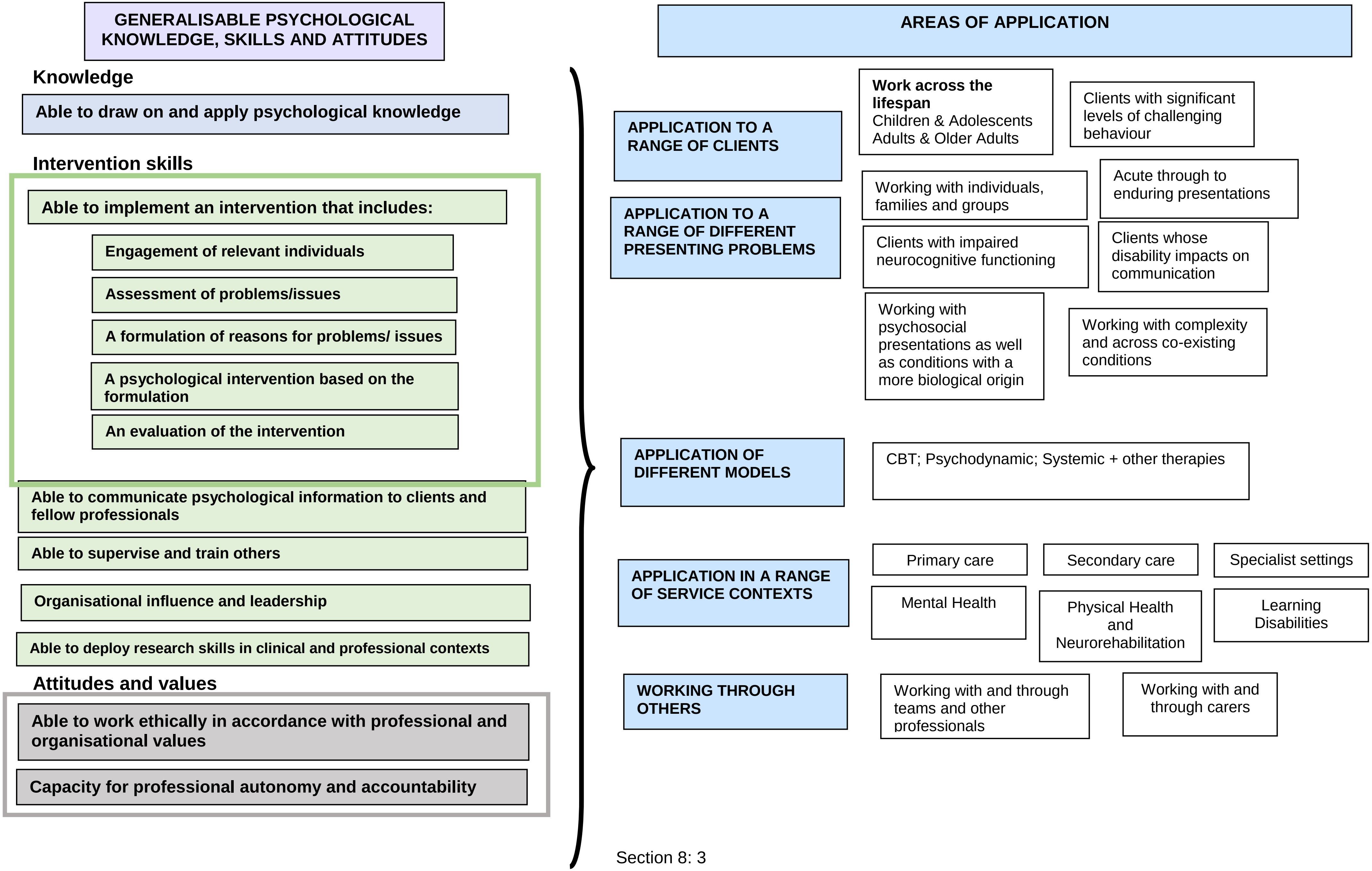
PLACEMENT CONTENT AND LEARNING OUTCOMES

Placements offer a great diversity of experience. For this reason the basic template for the placement contract (which sets out the expected trajectory for the placement) restricts itself to signalling the broad areas of placement content. This template can be found in Section 9. Essentially placement content will reflect:

a) the clinical opportunities available in the clinical service
b) the supervisor’s “generic” capacities and interests
c) the areas in which the supervisor has specialised knowledge
c) the trainee’s experience to date, as identified by their clinical log
d) the trainee’s training needs, as identified by their reflective practice log and prior supervisor feedback

Specific learning outcomes will reflect the criteria set out in the supervisor feedback form, which specify the domains in which trainees are expected to demonstrate competence. While this structure remains constant across training, the way in which each of these domains are translated into learning outcomes in any one placement needs to reflect the work which is being undertaken. For example, a “capacity to engage clients and to form a working relationship” requires different skills when implemented in an adult psychological therapy unit, contrasted to a children and family unit. In most adult settings this usually involves engaging a single patient, whereas in a children’s service it usually involves engagement or liaison with a number of individuals, including the child their parents and families.

Outline of Clinical Psychology training



GENERALISABLE PSYCHOLOGICAL KNOWLEDGE, SKILLS AND ATTITUDES

Knowledge

Able to draw on and apply psychological knowledge

Intervention skills

Able to implement an intervention that includes:

- **Engagement of relevant individuals**
- **Assessment of problems/issues**
- **A formulation of reasons for problems/ issues**
- **A psychological intervention based on the formulation**
- **An evaluation of the intervention**

Able to communicate psychological information to clients and fellow professionals

Able to supervise and train others

Organisational influence and leadership

Able to deploy research skills in clinical and professional contexts

Attitudes and values

Able to work ethically in accordance with professional and organisational values

Capacity for professional autonomy and accountability

AREAS OF APPLICATION

APPLICATION TO A RANGE OF CLIENTS

- **Work across the lifespan**
  Children & Adolescents
  Adults & Older Adults
- Clients with significant levels of challenging behaviour
- Working with individuals, families and groups
- Acute through to enduring presentations

APPLICATION TO A RANGE OF DIFFERENT PRESENTING PROBLEMS

- Clients with impaired neurocognitive functioning
- Clients whose disability impacts on communication
- Working with psychosocial presentations as well as conditions with a more biological origin
- Working with complexity and across co-existing conditions

APPLICATION OF DIFFERENT MODELS

- CBT; Psychodynamic; Systemic + other therapies

APPLICATION IN A RANGE OF SERVICE CONTEXTS

- Primary care
- Secondary care
- Specialist settings
- Mental Health
- Physical Health and Neurorehabilitation
- Learning Disabilities

WORKING THROUGH OTHERS

- Working with and through teams and other professionals
- Working with and through carers

EXPECTATIONS COMMON TO ALL PLACEMENTS

Placement contract

After completing and signing the placement contract with their supervisor, the trainee should submit a PDF to the Electronic Trainee File System (ETFS) by the appropriate deadline (paperwork deadlines located at http://www.ucl.ac.uk/dclinpsy/clinicalplacement/clinplacement_documents/placement_and_paperwork_dates).

Appended to the contract should be Part E of the trainees' previous EPR-MPR form ('Feedback for the next supervisor'), signed by the new supervisor to show that this feedback has been received.

Note: We encourage trainees to share the whole EPR-MPR from their previous placement with their next supervisor, but for the purposes of the placement contract, it is just the Part E section that needs appending.

Expected workload

The type of work carried out in different settings varies, which means that there is no simple way of expressing the amount of work supervisors can expect trainees to undertake. However, as a rule of thumb trainees are expected to undertake at least 8 substantive pieces of clinical work *at any one time*.

Defining a "substantive piece of clinical work" is not straightforward it could be ongoing casework, but also indirect work (such as active participation in a clinical or professional meeting) is also relevant. Supervisors need to use their judgment to decide whether the work is 'substantive'. Sitting in a meeting where there is no expectation of much involvement is very different from acting as a key worker developing a care plan with other members of a MDT. In this sense "substantive" refers in part to the amount of time, as well as the emotional demand made by the work.

The number of cases a trainee sees over the course of a placement is not fixed, and the guideline here is not intended to indicate a maximum number. Trainees should expect to be kept busy, neither overworked nor underworked. Ultimately it is critical that trainees see the number of cases consonant with a good training experience. This means that trainees might see fewer cases in settings where work is very intensive and involves a large amount of collaborative working. Equally, in settings where the work was brief and self-contained, the caseload should be higher.

Observation of trainees, and modelling by supervisors

Observation is a two-way process – trainees observing their supervisor model a skill, and supervisors observing trainees implementing an intervention. These are both potent learning tools – used well they are far and away the most powerful ways of helping trainees to develop. The course expects them to be a standard part of all placements, not only because of their utility, but also because observation in particular is the only way to determine what a trainee *actually* does, as contrasted to what they report. This is critical to the supervisor's ability to determine that a trainee is proficient (and ultimately protecting the standards of the profession).

Most trainees benefit by observing their supervisors, and then moving progressively to more independent work. The speed with which this is done will vary according to the prior experience and (to a degree) the confidence of the trainee. It is often helpful to move through a cycle of: a) the trainee watching the supervisor b) the trainee and supervisor work together jointly c) the supervisor watches the trainee. This pattern is usually easy to implement when conducting assessments.

It is worth noting that observation need not be, and usually isn't, "live". Sessions can be recorded, and trainees are strongly encouraged to purchase a digital recorder. These are unobtrusive and produce a very good sound quality, meaning that there should be no technical bar to implementing recording as a routine part of supervision.

Supervisors should listen to at least some complete sessions, but time constraints may make this difficult to achieve on a regular basis. However, trainees can be asked to select extracts from a session for detailed review (for example, areas where they are puzzled by the way a session developed, or where they would like guidance on the implementation of a specific technique).

Observation should be seen as a routine part of training, despite the fact that being observed can sometimes be experienced as uncomfortable (by trainees and supervisors).

Structured observations

Trainees must complete at least one structured (rated) observation per six-month placement (at least two over the course of a 12-month placement). This observation should involve the use of a published or standardised scale or observation framework that is suitable for the placement type and/or model being utilised (e.g., Cognitive Therapy Scale- Revised (CTS-R) or UCL adherence rating scale). Example rating scales are available from the course team if required. The observation should be of a full assessment or therapy session (either live, or via audio/video recording).

Ideally, both the trainee and the supervisor would both rate the session, and would then subsequently come together to discuss the ratings and any feedback, reflections or developmental goals arising from the observation.

For clarity, these structured observations are formative only (unless they are CTS-Rs being completed as part of the trainee's work on the BABCP accreditation pathway), and for the trainee's development on placement. Therefore, the observation does not need to be 'passed' in order for the trainee to successfully complete their placement. However, trainees will be expected to provide evidence of the structured observation for each six-month placement, by uploading the completed supervisor observation ratings to the ETFS.

Monitoring therapeutic outcomes

Systematic monitoring of outcomes of interventions should be routine, in line with the principles of clinical governance and of practice-based evidence. Identifying the methods most appropriate to meeting this aim is a matter for supervisors to consider - the aims of services vary, many services have a basic 'minimum data set', and the way in which outcomes are monitored varies with client group.

It is important that monitoring is actively integrated into supervision – in other words, making use of test scores to support thinking about case planning, and using multiple measurement points and using formal procedures to track client progress in a systematic manner. It is also helpful to involve service users in monitoring – for example, by giving them clear feedback on the measures they have completed, making monitoring a collaborative exercise.

Obtaining client feedback is also integral to your work on placement, both to ensure client satisfaction with the service they are receiving as well as for your own professional development. Trainees are required to obtain client feedback using either local service tools (if available) or the UCL client feedback form (also available in an easy read format) This can be found under *Placement Monitoring and Paperwork* (http://www.ucl.ac.uk/dclinpsy/placement_monitoring_and_paperwork). Client feedback should be noted on the portfolio of clinical experience and discussed in supervision. Your MPR visitor will also ask you and your supervisor how you have made use of client feedback to develop your clinical practice.

Working with service users

In addition to direct client feedback, the course encourages trainees to think about ways in which they learn about the perspectives of service-users and carers. As this is harder to achieve when involved in a direct therapeutic relationship the course has specific suggestions about ways in which trainees can consult with service users to achieve this aim (see Section 10).

Research

In at least one placement trainees need to carry out service-related research (see Section 18). There may be further opportunities for service related research relevant to the work of the trainee, and if this is the case it should be discussed as part of placement contracting.

Teaching

Wherever possible trainees should be encouraged to make clinical or academic presentations to colleagues or to undertake formal teaching.

Report writing and correspondence

Entering information into the record is an important professional activity and the contracting process should include discussion of local Trust procedures as well as supervisor's expectations regarding the ways in which trainees document their work. This discussion should encompass clinical notes, clinical reports or letters to referrers, and also the ways in which supervision notes and recordings made for supervision are maintained.

In order to avoid any misrepresentation trainees should always sign themselves as "Trainee Clinical Psychologist".

Arrangements for ending placements

- Some months before the end of the placement there should be discussion of expectations regarding arrangements for ending (for example, arrangements for handing over clients, finishing reports (etc)).
- As described in Section 15, there must be a formal End of Placement Review *before the end of the placement* at which the completed Supervisors' Evaluation form and the Trainee Evaluation of placement form are discussed.

PLACEMENT CONTENT IN SPECIFIC SERVICE SETTINGS

It is helpful to outline the sorts of clinical activities usually associated with work with specific client groups – what follows applies to work in general adult mental health settings, to work with children and young people, people with learning disabilities, work with older adults, and work with people with severe and enduring mental health problems. This is obviously a slightly restricted range of service settings, but much of the guidance may be broadly useful in other areas of clinical activity.

In some areas BPS special interest groups or faculties have published guidance on training content, indicating suggesting the learning outcomes each of these professional groups would expect. These are referenced below.

The following is best seen as guidance – indicative rather than prescriptive, because the actual placement contract supervisors and trainees draw up needs to reflect factors such as the trainee's prior experiences and training needs, as well as the clinical work actually available.

GUIDANCE FOR THE FIRST PLACEMENT

The first placement for UCL trainees is in a service where they will see adult clients with mental health problems. Usually this is in an Adult Mental Health service, but it could also be located in a health setting, a forensic setting, or an older adult service.

Overall aims

The experiences available will reflect the work offered in the service, but as far as possible the placement should aim:

- to expose trainees to as wide a range of adult mental health conditions as is possible in the context of the service setting
- to familiarise trainees with the clinical skills which are used to manage and treat these conditions
- to expose trainees to the contexts in which treatment takes place
- to familiarise trainees with local organisational issues, including (wherever relevant) issues relating to team working

Induction

Supervisors will need to help trainee's induction to the NHS and to training, as well as their induction to work in the placement speciality. How much induction is needed will vary; most trainees have some prior experience of work in the NHS or similar settings. It is a good idea to start by finding out what trainees already know, what they feel confident about doing, and what they need to learn. Many trainees feel anxious and deskilled at the start of training, whatever their prior experience. Supervisors need to acknowledge and manage this while striking a balance between being over- and under-protective.

Trainees will need help in adjusting to their new role, and to begin their orientation to the profession and the placement; how much help will depend on their prior experience, competencies, anxieties, special interests, (etc). For this reason the induction needs to be fairly systematic and tailored to the trainee's needs. Some apparently basic aspects of induction should probably be covered for all trainees, regardless of their experience. This will include a systematic (even if informal) introduction to other members of the unit, and especially to fellow professions and colleagues. They will also need instruction on institutional procedures and policies, ranging from the formal (eg management of health and safety, consent and confidentiality, unit policies and plans), to the "political" (who's who in the hierarchy and how they should be approached), as well as the informal (where to get coffee and lunch).

Skill development

There are a range of skills which trainees should acquire in this placement, some of which they may have started learning about in previous posts. As a guide, initial skill development probably focuses in the following areas:

a) Basic professional skills

- Basic office procedures (such as administering referrals, arranging appointments and responding to cancellations).
- Basic professional and management skills related to client contact (e.g. understanding and respecting confidentiality)
- Working with diversity - building confidence in work with individuals of varying demographic backgrounds, ages and ethnicity)

b) Specific assessment and formulation skills

- Techniques and procedures relevant to structured assessment and evaluation, such as relevant standardised assessment procedures (eg Beck Depression Inventory etc) or psychometric techniques
- Interviewing and assessment skills (eg taking a history, identifying significant clinical issues, developing and testing-out hypotheses)
- Formulation skills (eg developing the capacity to formulate and to present formulations in form and language appropriate to clients, colleagues and to referrers).

Unless the service *never* receives appropriate referrals, a good target would be for trainees to undertake at least two formal psychometric assessments, and to communicate test findings to client(s) and to colleagues.

c) Specific intervention skills

- Engagement skills (establishing rapport, , engaging the client and building and maintaining a therapeutic alliance)
- Generic therapeutic skills, such as listening skills or expressing empathy in listening
- Learning to use a range of clinical techniques and approaches, applied in the context of a thorough assessment and formulation

The type of intervention trainees apply should reflect the evidence-base, but as noted below it is also important that supervisors focus their supervision on models with which they are familiar.

d) Learning from experience

- Developing a capacity to reflect on (and hence learn from) experience
- Beginning to integrate academic knowledge and clinical experience

Range of clinical cases

Direct clinical work is expected to form the core of this placement, so that trainees can begin to acquire assessment and intervention skills. Though trainees should gain a range of experience, no one placement can be expected to provide comprehensive coverage. Supervisors should not feel burdened by trying to find types of cases which they do not normally treat themselves. However, when selecting cases, it may be useful to consider the categories below and to aim for variety:

- Cases from across the age range (while remembering that life stages are more important than chronological age).
- Problems of varying duration and severity - for example acute life crises or symptoms of recent onset through to longstanding psychological problems; milder presentations through to severe problems (eg personality disorder, psychotic presentations).
- A range of presenting problems - the most important factor is to ensure that problems are not drawn from just one diagnostic category or problem area.
- Cases which reflect the usual diversity of local populations, in terms of gender, class and ethnic and cultural background
- If possible, it is helpful if trainees gain experience with more than one different level of intervention (e.g.: individual, couple, family, work with carers/staff)
- If possible trainees should have experience of indirect working – for example with professional carers (e.g. developing an intervention programme on a ward), or with carers (e.g. helping families to think about coping with a relative's behaviour).
- As many cases as possible should be seen by the trainee from assessment through to termination, so that there is experience of the "cycle" of an intervention.

Range of clinical approaches

- If possible trainees should be exposed to more than one therapeutic approach. However, whether this is feasible depends on the availability of appropriately skilled supervision, and this will vary - some supervisors are confident in applying more than one approach, others less so. While it may not always be practical or appropriate to include direct experience of more than one orientation, there may be opportunities for indirect learning (for example, through discussion and observation of other members of staff).
- It is better for a trainee to learn about one approach thoroughly than for supervisors to attempt to cover approaches with which they are unfamiliar. Whatever experience is on offer, there should always be an openness to discussion of alternative approaches to treatment.

Working with other professionals

In most settings trainees will need to be familiar with the procedures used to co-ordinate client care across professional groups and potentially across agencies, and learn how to operate effectively with these systems. They should learn about the organisational processes that operate in clinical meetings and use this knowledge to make effective contributions.

Wherever possible trainees should gain experience of the work of teams, and of the ways in which psychologists work in teams. This should include both intra-professional meetings (such as psychology meetings) as well as inter-professional.

STRUCTURING ONE-YEAR PLACEMENTS IN THE FIRST YEAR

Almost all our first-year placements now last for one year. This has huge advantages for trainees (they can get settled-in to the work) and for supervisors and services (trainees can undertake much more meaningful pieces of clinical work, and supervisors recoup the hard work that goes into the induction period). If you are offering a one-year placement it is worth giving some thought to the way in which it is structured. These comments are intended as a supplement to the general placement guidelines.

The overall ‘shape’ of the placement should be planned from the outset, in order to make sure that full advantage is taken of the placement duration.

Settings where the focus will be on AMH for the whole year
Care should be taken to plan the placement in a way which ensures that trainees gain a diverse set of experiences. For example:

- work in more than one setting – there is no one prescription for this, but a mix of settings (eg ideally a mix which could include outpatient, inpatient, CMHT work)
- different approaches to intervention
- diversity in terms of complexity and challenge of presentation

Settings where the placement is shared with other services (such as health, older adult or substance abuse): Both trainees and supervisors need to be clear from the outset about the way in which placement experiences will be sequenced. For example, will there be two six-month blocks, or will the trainee be exposed to different settings in parallel? Who is supervising which aspect of the placement? Who is coordinating the experiences?

When placements are undertaken as two discrete six-month blocks, it is worth remembering that planning and induction for the second block can be carried out before the first placement ends. For example, in the last month of the first block trainees could spend half a day a week in the new setting. Equally, it may be sensible (both clinically and from the perspective of training) to plan for some carry-over of clinical work from the first placement into the second, in order to give the trainee a proper experience of longer-term work. All of this needs careful planning from the outset if it is to work.

Responsibility for liaison among supervisors: If trainees have more than one supervisor over the year, one supervisor should act as the coordinator of training, ensuring that overall professional development is being monitored, making sure that the components of training fit together, and being available to act as a link to the course for relevant personnel matters.

If there is a clear transition between AMH and other services there should be a formal "handover" meeting of the supervisors and trainee.

GUIDANCE FOR WORK WITH CHILDREN AND ADOLESCENTS

Overview

There is considerable variability in the pattern of services for children and adolescents, and hence in the nature of the experience which can be offered to trainees. Rather than specifying the essential components of a child placement, the outline contract which follows indicates the broad areas to which trainees should have some exposure. This allows the supervisor and trainee to specify the precise types of experience available in each unit.

In general, trainees need to be familiar with normal child development in order to understand the clinical presentations with which they will work. Ideally trainees without prior experience of work with children should have some contact with normal children as part of their induction.

All trainees would be expected to have exposure to direct work with children, work with families and parents, and liaison with other professionals and agencies (schools, Social Services, Paediatricians etc).

Induction and orientation

The aim should be to establish the trainee's familiarity with this area of work e.g.:

- their knowledge of 'normal' child development
- their prior experience with children (both professional and informal)
- their level of confidence in relating to children.

Where trainees are very inexperienced in this area, or lacking confidence, some contact with 'normal' children may help them to establish a knowledge base and increase their confidence – for example, spending time in a nursery, observing health visitors, observations. Encouraging trainees them to play or interact with the babies or children of friends or relatives may also be helpful, though this should be structured and discussed in supervision.

There should be explicit and careful discussion of local child protection procedures, and an understanding of the roles of the clinical psychologist and the trainee in this area.

Direct case experience

Casework, undertaken independently or with the supervisor should include exposure to work not only with children, but where relevant with their parents and families

In planning clinical experience (but obviously dependent on the service setting) supervisors should try to achieve as broad a range of experiences as possible:

Ideally trainees should undertake:

- a range of assessment methods (including psychometric assessment) and observations across different contexts
- a range of treatment approaches
- a range of presenting problems
- as wide a range of ages as possible (0-5; 5-11; adolescents)

Trainees should be exposed to clients from as many differing social settings, social classes and ethnicity as is feasible.

DCP Faculty guidance

The Faculty for children and young people have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be found as Section 8 Appendix 2 of this handbook or downloaded from the BPS website.

GUIDANCE FOR WORK WITH PEOPLE WITH LEARNING DISABILITIES

Overview
By working in a learning disabilities service the trainee should develop a good understanding of the role of the clinical psychologist. This is best done through:

- direct and indirect working, giving experience of assessment and intervention procedures and techniques with people with learning difficulties - ideally both adults and children
- work in a variety of settings
- work with other professionals

Induction and orientation
Trainees need to acquire knowledge (through reading, discussion and structured observation) of historical and current practice and thinking about psychology services for people with learning difficulties. This includes consideration of the values that underpin services, service organisation and systems.

Direct Client work

Assessment and investigation: It is essential that the trainee gain experience of the application of a range of methods of assessment and clinical investigation. Some examples include: semi-structured interviewing, direct observation, psychometric assessment, functional analysis, risk assessment, etc. Experience of working with an interpreter is also desirable.

Intervention: It is essential that the trainee gain experience of a range of methods of intervention, e.g. psychotherapeutic, behavioural, cognitive behavioural and counselling interventions. One piece of direct work with a client through the three phases of assessment, intervention and follow up is a suggested requirement.

Care planning systems: It is essential that the trainee gain experience of care planning systems, either directly or through observation, e.g., contributing to community care assessments, the care programming approach, etc.

Range of clients: It is essential that the trainee gain some experience of the work of a clinical psychologist with a wide range of clients of different abilities, age, gender, race and culture. Trainees need to gain experience of clients who have challenging needs; autism; dual diagnosis.

Group work: It is desirable that trainees gain experience of group work with people with learning difficulties (e.g. running an assertiveness group, or a bereavement group or a transition group).

Indirect work
Work with family carers: Where possible trainee should gain experience of work with the family or family member of a person with learning difficulties.

Work with 'professional' carers: Trainees should work with a paid carer/staff team through the three phases of assessment, intervention and wherever possible, follow-up.

Work with MDTs, other professionals and other agencies: Trainees should gain experience of work with other professionals from a range of services/agencies.

Work within systems and organisations

Knowledge of service organisation: Trainees need to gain – and apply - knowledge of the role of the psychologist at the level of the service organisation eg: local service development, implementing community care legislation.

Range of settings: Trainees should have the opportunity to experience work in a range of settings (e.g. residential, educational, day-care settings, hospital, home, etc). They should also gain an understanding of service networks and their importance.

DCP Faculty guidance
The Faculty for learning disabilities have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be downloaded from the BPS website.

GUIDANCE FOR WORK WITH OLDER PEOPLE

Overview
Since no two placements with older people will offer the same clinical experience it follows that placements will vary with the setting, the supervisor's areas of expertise and the trainee's experience and needs. However, some of the basic areas of experience that will usually be met by this placement include:

- assessment and interventions of both functional and organic problems
- direct work with elderly people and indirect work with families and other carers
- experience which helps the trainee understand the organisational and legislative context of services for older adults
- experience of liaison with statutory and non-statutory agencies

Induction and orientation
Trainees need to acquire knowledge (through reading, discussion and structured observation) of historical and current practice and thinking about psychology services for older people. This includes consideration of the values that underpin services, service organisation and systems.

Direct case experience
Trainees should gain experience in the following areas:

a) Clients presenting with functional disorders. Ideally trainees should see a range of patients (both male and female), ranging in age from the elderly (65 - 74) to the very elderly (85+,) presenting with a wide variety of functional disorders, including depression, anxiety and inappropriate behaviour.

b) Clients with dementia. It is desirable that they see a variety of patients ranging from those with mild memory impairment through those with a moderate focal impairment, (such as dysphasia or visual agnosia) to those with a global cognitive impairment.

c) Patients with adjustment problems consequent on the psychological and physical events common in this age group, such as retirement, stroke or disability.

Service context
Trainees work should take should take place in a variety of settings, for example, the patient's own home, day centres, long stay hospital, or residential homes.

Indirect work
Trainees should gain experience of indirect work with and through staff, families and other carers. It is desirable that indirect work with staff takes place in more than one setting and with staff from different disciplines (e.g. nurses, medical staff, social workers, health visitors, or occupational therapists).

Assessment skills
Developing clinical interviewing skills and building rapport with older people requires basic knowledge of the range of physical problems older people commonly have to contend with (for example, heart disease, respiratory problems, arthritis and other mobility difficulties), as well as impairments of sight and hearing. In addition, it requires an awareness of social problems such as poor housing, financial constraints and social isolation.
The person's previous life experience, experience of loss and former coping strategies, both cognitive and behavioural, must also be built into the assessment procedure.

In order to conduct effective psychological care the trainee should be able to conduct a holistic assessment of the person's current situation (including physical, environmental, social and psychological domains) and be aware of the potential interaction between these different variables.

Trainees need to acquire knowledge in and experience of using a range of formal assessment procedures specifically designed for the elderly including cognitive and behaviour analysis.

Intervention skills

Trainees should have an appreciation of the wide range of psychological interventions and the ways that these are adapted for work with older people (e.g. therapies, interviewing and assessment techniques). They should also gain knowledge of psychological therapies designed for use with older people.

If possible trainees should have experience of designing individual care plans with realistic but objective goals and planned interventions. This experience can be gained either in direct work with the patient or in indirect work with staff, relatives or other carers.

Again if possible, trainees should gain experience of group interventions designed for older people and/or their carers (e.g. reality orientation, reminiscence therapy, task-orientated staff group, staff support group, relatives support group).

Experience of the organisation

Trainees should gain an understanding of the potential contribution that Clinical Psychologists can make within the wider service provision of both the Health Service and the Social Services, including their input to service planning.

Trainees should gain experience of working alongside and together with other professionals and develop an appreciation of their responsibilities, problems and concerns. If possible they should also gain experience of provision for older people based in the voluntary sector.

DCP Faculty guidance

The Faculty for psychologists working with older people (FPOP) have published a good practice guideline which identifies good practice in relation to Clinical Psychology training. This expands on much of what is written above, and can be downloaded here

OLDER PEOPLE:
GUIDANCE ON GAINING EXPERIENCE, AND FOR MINIMUM LEVELS OF EXPERIENCE

Background

BPS accreditation criteria specify that trainees should gain experience with individuals across the lifespan. This means that at some point in their training they need to have undertaken worked with older adults. How they gain this experience varies from trainee to trainee – there is no requirement for trainees to undertake a complete placement in work with Older Adults. Though the majority of trainees do undertake such placements, they can gain also experience of work with older adults in the context of other service-settings. This Section describes the ways in which this experience can be gained, and the criteria for minimum experience.

What defines clients as "Older Adults"?

Defining ‘older adults’ is contentious, both for service users and for services themselves. Within the NHS the age cut-off for services for older people varies - in some settings it is 65, in others 70, and in some locations AMH services see individuals of all ages unless there is a clear indication that they need the specialist input of an older adult service.

For good reason, accreditation criteria do not define older adults by age, though there is a common misconception that it is defined as 65+. It may be better to think of life-stage rather than age, though age cannot be disregarded entirely - a good rule of thumb might be 60+.

In terms of trainees’ learning, type of presentation will often be as important as age. A 65 year old presenting with a self-contained specific phobia treated as an out-patient might not give trainees much insight into problems confronting individuals in later life. In contrast, there could be much to learn about issues confronting individuals in later life from contact with a socially isolated 62 year old who has recently lost his/her partner and been retired from his/ her job. However, there are limits to how far the issue of age can be ignored - for example, a 48 year old with dementia would not be an appropriate case - the issues raised would be different from a later-onset presentation.

Gaining experience in placements with older adult service contexts

There are often opportunities to work with older adults work in a range of speciality settings, not only in Adult Mental Health services, but also other areas – for example, forensic settings, in work with people with serious and enduing mental health problems, health placements, or within neuropsychological units. As trainees are expected to acquire a ‘portfolio’ of experience across all three years of training, experience of work with older people can be gained in more than one placement.

MINIMUM KNOWLEDGE AND EXPERIENCE OF WORK WITH OLDER PEOPLE

Assessment and awareness of neurological and organic presentations
It is desirable that trainees should have direct experience of assessing individuals whose management requires understanding and (where relevant) management of neurological and/or organic problems. Relevant presentations would be individuals with:

- dementia
- the sequelae of stroke
- adverse reactions to medications
- sleep problems

While psychometric assessment will be important in formulating such presentations, broader assessment approaches will usually be needed if trainees are to develop a holistic formulation and management plan. There will usually be some contact with and support for the client and their carers (both family and where relevant professional carers), along with contact with members of other disciplines in order to develop care plans.

Functional presentations
As noted above, chronological age can be misleading as a way of thinking about a client’s needs, and it is important that trainee’s learn how to develop a frame of reference that enables them to formulate the pertinence of life-stage and development to a clinical presentation. From this perspective there is no formula for indicating which cases will be most relevant to learning, though clearly client’s in late old age are more likely to present with issues in which the psychological and physical consequences of ageing are more prominent.

Indirect/organisational work/service knowledge
Ideally trainees should have some contact with carers of older people - this would usually be gained in connection with the clinical work outlined above (eg gathering information as part of a functional assessment; implementing an intervention or giving feedback about the outcome of an intervention or assessment).

It may be possible for trainees to gain experience of service and organisational issues relating to older people (for example, through visits to local services and discussion with local psychologists working in these services).

Number of cases
Trainees will be expected to see at least four cases of individuals in later life.

- presentations can be either functional or organic (as described above)
- the client’s presentation and circumstances should be representative of problems faced by individuals in later life
- the trainee’s clinical involvement should be substantive (usually an assessment followed by direct intervention, or by indirect intervention (where the trainee is involved in making clear recommendations for further intervention through the agency of other individuals which are themselves monitored for efficacy)
- cases can be seen in any clinical setting

GUIDANCE FOR WORK WITH INDIVIDUALS WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS

Overview

Placements should be designed to equip the trainee with sufficient knowledge of the client group and of the techniques and competencies of the practice of clinical psychology in settings for the assessment, treatment and management of people with long term, serious mental health problems.

Not all placements will meet these aims in the same way, as there is wide variability in the pattern of services. Some offer trainees the opportunity to carry a considerable personal caseload, others are characterised by more indirect, organisational work, or research, or work with and through non-psychologists. Trainees' experience varies widely as well: some will come on placement already familiar with individuals with serious mental health problems; others will never have met people who hear voices, or will have no experience of work in an inpatient setting. Some attention to identifying the trainee's and the supervisor's 'starting points' in relation to these issues will probably pay dividends later on.

It will be worth talking with the trainee to see what clinical competencies they have acquired in prior placements or positions. Assessment and intervention skills acquired in adult mental health, learning disabilities and work in the care of older people, etc, will obviously be very relevant to work in psychiatric rehabilitation.

Induction

It would be helpful to find out what knowledge the trainee has about this area of work at the outset of the placement. This will vary according to the timing of the placement in relation to academic teaching, and the trainee's previous experience and reading. Essential basic knowledge (much of which is covered in academic teaching) probably includes:

- The concept of schizophrenia, bipolar disorder and the major personality disorders.
- History of services for long term care (institutional vs. community care).
  Psychological models/concepts (needs, skills, quality of life, social support, values based, recovery)
- Assessment (broad based functional plus traditional psychiatric and psychological).
- Treatment approaches (individual, group, care management and care planning).
- The organisation and range of services (early intervention, crisis resolution and assertive outreach services, as well as more traditional community and inpatient psychosocial rehabilitation services) as well as understanding of quality issues, support of carers and service development
- Relevant research strategies (e.g. for audit and small-scale service evaluation or quality improvement projects)

Trainees acquire knowledge in different ways: through structured personal experience, reading, observation, feedback and discussion in supervision. It is also the case that not all this knowledge can be acquired at once – and much of it depends on matching experience to any reading.

Areas of clinical experience

- Interviewing (clients with communication and attention difficulties)
- Formulation (incorporating information from a multiple theoretical base)
- Realistic goal setting (balancing prognostic factors and evidence of effectiveness of intervention strategies)
- Design of appropriate interventions (to include direct, indirect and organisational interventions)
- Care management (negotiating targets with client and relevant others)

- Work within the organisation (applying psychological models to the organisation, communicating effectively with other staff, participation at all relevant levels of the organisation)
- Evaluation methods including client self-assessment

Direct and Indirect Experience

Direct individual work requires an understanding of the personal and social/economic impacts of psychosis and severe mental health presentations, as well as strategies for and techniques of psychological and psychosocial interventions. Indirect work through multidisciplinary teams is especially important in psychosocial rehabilitation and a positive experience of teams should be an important feature of a trainee's placement. This experience would include:

- learning about the roles and responsibilities of the range of professional and non-professional colleagues in both statutory and non-statutory services
- becoming aware of the issues of communication and liaison involved in care management
- opportunities to work alongside colleagues from other disciplines and agencies
- presenting clinical or theoretical material to multidisciplinary or multi-agency team meetings

SECTION 9: BASIC TEMPLATE FOR ALL PLACEMENT CONTRACTS

This section sets out the basic “headers” which all placement contracts should contain. The expected content of placements is detailed in Section 8.

Trainee-specific learning outcomes

The contract should identify any specific learning outcomes or areas of experience that the trainee is expected to acquire while on placement, based on initial discussions with the trainee, which (with the exception of the first placement) should also consider:

i) feedback from the supervisor of the previous placement regarding any areas for further work
ii) information about prior experience and learning contained in the trainee’s Clinical Portfolio

Standard content for all placement contracts

1. Placement start date and end date

2. Expected supervision arrangements:
   - frequency and duration
   - any opportunities for additional supervision by individuals who are not the placement supervisor
   - arrangements for supervisory cover during expected and unexpected absences

3. Plans for induction and orientation, including:
   - Confirmation that all mandatory training is up to date before starting the placement
   - Arrangements for identifying any additional local training that needs to be completed.

4. Specific plans for modelling by the supervisor, and specific plans for observation of the trainee
   - arrangements for recording
   - arrangements for live observations (including structured observation)

5. An outline of the areas of clinical work which the trainee and supervisor anticipate will be undertaken in the placement, including details of:
   - Expected opportunities for direct and indirect clinical work
   - Expected caseload and expected range of clinical activities
   - Expectations of the type of clients who the trainee will work with, including arrangements to ensure appropriate range and diversity of clients
   - Expected therapeutic approaches to clinical work
   - Opportunities for team and interprofessional working

- Expectations regarding clinical and professional meetings which the trainee will attend

6. Arrangements for formal monitoring of client progress and evaluating outcomes of interventions

7. Any service-related research which will be undertaken

8. Any opportunities for service-user consultations on placement

9. Any opportunities for the exercise of leadership skills (e.g. supervision, consultation)

10. Any opportunities for teaching and/or for clinical presentations

11. Expectations of the service and the supervisor regarding report writing and correspondence, including expected timescales for completion of clinical reports

12. Any visits to local services which are seen as integral to placement learning

13. Plans for ending the placement, to include:
    - completing reports and other aspects of placement administration
    - procedures for handing-over ongoing clinical work
    - setting a date for the end of placement review meeting

SECTION 10

A) CONSULTING WITH SERVICE-USER REPRESENTATIVES AND SERVICE USERS/CARERS WHILE ON PLACEMENT

B) INTER-PROFESSIONAL LEARNING: CONSULTING WITH COLLEAGUES WHILE ON PLACEMENT

CONSULTING WITH SERVICE-USER REPRESENTATIVES AND SERVICE USERS/CARERS WHILE ON PLACEMENT

Background

Although trainees have extensive contact with service-users in each placement this will usually be in the context of a formal professional relationship, where they are seeking actively to help the service user resolve problems or difficulties.

This focus usually means that there are few opportunities to step to one side of the intervention and explore the service user's experience of the service. There are a number of reasons for this. The power imbalance inherent to even the best-run and most sensitive service makes it harder for service users and carers to express their views directly. It is also quite a challenge for trainees to maintain a focus both on delivering a competent intervention as well as seeking to learn more about client's perspectives on, and experience of, the services they are receiving.

In order to gain a clearer sense of service users' concerns and outlook a different approach is needed in which the aim of contact is not 'therapy' but more a consultation - an opportunity actively to seek out the expertise service users have developed on the basis of their contact with clinical services.

Course requirements

In at least two of their six placements trainees should organise contact with service user organisations, or service users/carers. There are two primary objectives:

a) to develop a clearer sense of service-user issues, concerns, experiences and perspectives, and to discuss what is learned from this within supervision.
b) to gain experience of initiating this sort of contact (with guidance on how this is best done from the supervisor or the Course). In itself, learning how to initiate such contacts is an important area of skill development.

Nature of the consultation

This contact could take many forms, but it is crucial to avoid any exploitation of individual service users. An example of how this can arise is when one or two service users find themselves being asked repeatedly to undertake this sort of consultation (perhaps on the basis that they have a reputation as being helpful and approachable). This can become an abuse, as can the expectation that they should offer their time for free.

To avoid this sort of problem it makes most sense for trainees to meet with members of local organisations which represent service users and/or their carers. Because these individuals are tasked to represent the views of service users their role is entirely congruent with the task being undertaken.

It may be the case that trainees also have the opportunity to meet with service users and/or carers in the clinical service within which they work, although this should not involve individuals with whom the trainee has current direct or indirect clinical responsibility. It is important that trainees discuss this option carefully with their supervisor in order to ensure that there is no risk of exploitation. A part of this discussion involves identifying how the service user consents to participation (in particular, how to ensure that they are making a free choice – which includes declining to help).

Making these contacts work depends on the trainee establishing an appropriately egalitarian relationship where it is clear that the trainee is explicitly hoping to learn from the service user representative - on the basis of their experience the service user is (in a specific sense) the expert. It is important that the trainee approaches this task in a manner which does not reproduce the formal role-relationships which characterise their more usual contacts with service users.

Number of meetings

In many cases the consultation may take the form of a one-off meeting, but the number of meetings will depend on the service context and the trainee's aims.

Making contact with service users

In some locations (such as a residential rehabilitation unit or in a CMHT setting where service users attend a day programme) it is probably fairly straightforward to initiate contacts with service users with whom the trainee is not directly involved. In other settings access might be more difficult – for example, in an outpatient service it could be a breach of data protection to access client records in order to identify service users for this purpose, as this would be outside routine clinical service provision. Discussion with supervisors should help to clarify what is, or isn't possible in any particular setting.

Consultation with current service user forums

As an alternative to making contact with individual service users trainees could become involved with existing service user forums. As noted above, in some settings this might be the only appropriate mode of consultation.

Previous examples of service user consultation

In February 2015, the Course surveyed trainees across the three-year groups to find out what activities were taking place on placement to involve and consult with service users/carers. Below are some examples of servicer user consultation projects that may assist you in developing your ideas:

- Consulting with service users in the development of the Service Related Research Project (e.g. interview schedules/questionnaires).
- Consulting with service users on the content of therapeutic materials and/or service materials (e.g. leaflets)
- Consulting with service user groups and/or local community forums to provide information on service provision and improving access to services.
- Meeting with service user/carers groups to gather information on experiences of how services are delivered. Feeding this back to the team with the aim to improve service provision (e.g. developing a service leaflet)
- Helping to set up a peer led support group

Support for planning the consultation, and supervision of the work

Trainees should take the initiative in planning this consultation, as this is part of the aim of the exercise. However, it is important to involve the supervisor at the planning stage:

- to ensure that the plan is viable
- to ensure that the approach to service user representatives is appropriate and sensitive to their needs
- to clarify the areas the trainee would like to focus on

Trainees should discuss the consultation(s) with their supervisor as part of routine supervision, not only to consider the consultation itself but also the implications of what is being learned for the placement as a whole. It is likely that they need to consider how to manage a number of boundary issues when setting up the consultation – for example:

- how to be clear with the service user about the purpose of the contact
- contracting length and frequency of meetings
- identifying limits - for example,
    - expectations – e.g. making clear that there are limits on your capacity to take forward any complaints about the service, bearing in mind your role
    - confidentiality - e.g. whether relevant feedback about the organisation of services is discussed with other professionals, and if so whether the service user would prefer to maintain anonymity
- ensuring that the sessions do not become therapy
- thinking about whether and how any service issues the service user raises are fed back to the service

Although it is appropriate for most discussion to take place in the context of placement supervision, trainees should also feel free to talk to their Tutor (for example, to clarify Course expectations or to talk about how the exercise went).

Building in feedback to the service user: Some consultations might lead to positive changes in the service, and if this is the case it would be good practice to give feedback about this to the service user representative/ service user.

Course monitoring of the consultation
Formal monitoring of the consultation will be via the supervisor, who will be able to comment on how this exercise has gone in their Feedback form and at MPR.

B) INTER-PROFESSIONAL LEARNING: CONSULTING WITH COLLEAGUES WHILE ON PLACEMENT

Background

The main way in which trainees engage in learning about other professions is through their time on placement, Most clinical settings involve working in teams with a range of clinicians, and it is through this that trainees can expect to learn about the roles, functions and assumptions of different professional groups, and the ways in which their skills are deployed. However, this can be implicit rather than explicit learning, with the risk that assumptions about each other's roles are not tested or challenged.

Learning about the work of other professions is usually referred to as Inter-Professional Learning (IPL). On some programmes IPL is taught as part of the curriculum (for example, by having members of different professions sit in the same lecture), but this can be a passive process which doesn't promote learning about the work of others. As such, a more active and direct approach has been adopted by the programme.

Inter-professional learning: Consulting with colleagues while on placement

In at least one placement, trainees are expected to undertake an IPL exercise. This involves identifying a mix of professionals[1] from the team with whom they are working, and meeting individually with them. This could be done through a meeting specifically arranged for this purpose or in the context of joint work with or observation of members of other disciplines (though if the latter, care needs to be taken to ensure that there is adequate time for discussion).

Both parties would be expected to discuss:

a)_their route into training (e.g. what qualifications and experience are required)
b) the nature of their training (e.g. length of training, how it is structured, an idea of the content, etc)
c) how they see their role in the team, and how this relates to their background training
d) what they see as similar or different about their roles, and how this impacts on working as a team

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[1] The number of professionals with whom meetings are set up will reflect the range of professions with whom the trainee is working. In a context where there are a lot of different professions working together then judgment should be used to select (for example) no more than 3 or 4 individuals with whom to meet.

It is important to stress that for this to work well it should not be a ‘tick-box’ exercise, but one approached with a spirit of curiosity about the questions – many of which trainees will not know the answer to. It should also be a two-way process, because work colleagues may well know little about the details of training in Clinical Psychology.

Trainees should prepare a short report (no more than 500 words), usually structured in relation to the four points above. As such it should cover the main learning points from this exercise, with an emphasis on the trainee’s understanding of the roles of members other disciplines, their preferred models of working, and the implications for interprofessional working).

The report and the exercise should be discussed and reflected on supervision.

The report is not formally evaluated, but should be countersigned by the supervisor and submitted to the college via the Electronic Trainee File System (ETFS; under the Interprofessional Learning section, into ‘IPL Exercise’).

SECTION 11: ASSESSING TRAINEE PROGRESSION ON PLACEMENT OVER THE THREE YEARS OF TRAINING

Background

Expectations of a trainee's performance change as they progress through training, gaining more direct experience of clinical casework and growing into their professional role. However, benchmarking these expectations is a challenge both for the Course and for supervisors.

Part of the problem is that the same sets of fairly high-level competences are assessed in all placements – for example, a capacity for engagement, assessment, formulation and intervention is expected from the start of training. This means that the domains of competence remain largely the same over training, but there is a shift in the criteria used to appraise trainees – for example introducing factors such as the *level* of proficiency, or the capacity to practice skills autonomously, spontaneously and fluently. Over time trainees should show the benefits of learning from a range of contexts and clients, such that their knowledge and skills are readily applied to novel clinical situations, they are able to understand and respond to increasingly complex clinical phenomena and professional contexts, and demonstrate an increasing sophistication in the way they implement interventions. All of this is reflected in the BPS Accreditation Criteria, which identify a core set of 'transferable skills' which underpin the work of Clinical Psychologists: these skills are honed through their application to a wide range of clinical contexts, resulting in the level of performance expected of a qualified Clinical Psychologist.

The challenge is to anchor these abstract ideas in a way which enables them to be rated with reasonable reliability.

Global benchmarks for trainees at different stages of training

The supervisor's feedback form focuses on a number of domains; in each of these supervisors indicate whether they feel the trainee has achieved the right level of competence for their stage of training, or requires further development. Defining specific expectations for each stage of training might be possible, but is probably unhelpful – the result would be a long list that most supervisors would find difficult to apply. Instead it may be more useful to think in terms of global benchmarks which reflect the sense that progression is marked by an increased capacity to manage complexity and to operate autonomously.

Year 1

Knowledge Trainees should be able to draw on basic knowledge about psychological models; while this will be limited initially it is reasonable to assume that this develops over time, in line with academic input and their own background reading.

Competences: Initially there will be an emphasis on generic competences (such as engagement and building rapport), though through the first year there is an expectation that trainees will acquire specific technical intervention skills related to the placement.

Theory-practice links: The capacity to identify theory-practice links and develop hypotheses and formulations may be limited initially, and trainees will usually require explicit and structured support from supervision in order to develop this area.

Supervision and level of autonomy: Trainees are likely to require detailed, structured guidance from their supervisors, but from an early stage they should show an awareness of learning needs, be an active participant in supervision and demonstrate a capacity to learn from feedback. Over the year trainees should be able to take an increasingly active role in identifying the supervision agenda.

Professional style and role: Trainees should demonstrate an understanding of their professional role and that of their colleagues, though at this stage they will be learning about how these roles operate in practice (i.e. in and thought the way services are organised). Even if their role is limited at this stage, they should be able to communicate effectively and professionally with colleagues in formal and informal meetings.

Year 2

Knowledge: Trainees should be able to draw on a reasonably broad range of knowledge of psychological models,

Competences: At this stage trainees should have a reasonable repertoire of basic skills.
Generic competences such as engagement should be in place (though allowance needs to be made for adjustment to new client groups or contexts). This being so the focus should be with the development of specific technical intervention skills.

Theory-practice links: A capacity to identify theory-practice links should be evident. While this may require structured guidance from supervisors, particularly in new, complex or high-risk situations, there should be a sense that this is an increasingly collaborative process.

Supervision and level of autonomy: Trainees will still require active, structured guidance, but over the year should demonstrate an increasing capacity to “filter” the material they bring to supervision (i.e. to identify what is relevant/ pertinent) and to structure and organise their presentations. They should also be able to present plans for taking the clinical work forward, along with a rationale for doing so.

Professional style and role: At this point trainees should be able to demonstrate a capacity to reflect on their role and that of others, to bring a psychological understanding of the way in which systems operate, and to be a more active participant in the organisation/ service in which they are working.

Year 3

Knowledge: Trainees should be able to draw on a wide range of knowledge about psychological models, and show a capacity to integrate ideas from across these models.

Competences: At this stage trainees should have a broad repertoire of skills and competences that they are able to apply with some fluency. Trainees should show an increasing capacity to manage clinical contexts characterized by higher complexity/risk.

Theory-practice links: There should be a clear capacity to make links between theory and practice, to integrate ideas and approaches,

Supervision and level of autonomy: Trainees should demonstrate an increasing capacity for autonomy and for self-direction, with the result that supervision should be characterised by an increasingly collegial style.

Professional style and role: Trainees should be able to make an active professional contribution based on their understanding of their role and that of others, to communicate effectively and professionally, and to offer advice/consultancy. They should also be able to reflect on any conflicts within the service organisation and be able to use psychological models to consider how best to work with this.

Appraising competence developmentally – some factors to take into account

The global benchmarks above try to capture the expectations can have of a trainee at each stage of training. If a trainee is falling below expectation it can be useful to formulate the reasons for this, especially when this reflects an absence of opportunity rather than a deficiency in learning. For example when they start the course first year trainees vary widely – some have extensive clinical experience, some more limited. This means that expectations about their capacities need to be tailored to their prior learning, and supervisors will need to distinguish between difficulties which are developmentally appropriate (the trainee simply needs more experience) and those which may be flagging problems in skills acquisition.

Closely linked to this point, in the early stages of training it can be especially difficult to distinguish between problems of learning which are developmental and will resolve with more experience, and those which are flagging a substantive problem which will recur, and where early identification is both appropriate and helpful. Perhaps because most psychologists tend to see problems as resolvable (and the spirit of training is that people can change and improve) supervisors can be reluctant to flag concerns, even when problems are apparent. However they need to try to sift the evidence and not make the assumption that improvements will occur at a later stage of training.

Finally, trainees sometimes arrive at placement with less experience of specific clinical procedures or interventions than supervisors might expect. Hopefully initial discussions at the start of the placement will help supervisors formulate the reasons for this. For example, trainees take different pathways through training, and so the problem could relate to the absence of opportunities in previous placements. Equally it could reflect difficulty in learning from experience, and hence reflect a more substantive problem. As above, supervisors will need to reflect on, and collate evidence for, the likely roots of the problem.

SECTION 12: OVERVIEW OF PROCEDURES FOR MONITORING PLACEMENTS

For the purposes of the Examination Board, training is divided into 6 six-month placement periods over three years. The Course formally monitors progress in each placement period through the Mid-Placement Review (MPR) and the End of Placement Review (EPR).

One-year placements are deemed to comprise two six-month placement periods, each part of which requires a Mid-Placement Review and an End of Placement Review.

The MPR meeting involves a college visitor (usually the trainee's course tutor), the supervisor(s) and the trainee.

The EPR meeting usually takes place with the supervisor and trainee alone. However, in cases where significant difficulties have been identified (either at the MPR or at any other stage in the placement) the college visitor will also attend.

Any concerns about the placement which have implications for its overall evaluation must be identified as early in the placement as is possible. For supervisors these concerns will relate to problematic trainee performance or competence; for trainees these will be issues related to supervision or to the organisation of the placement.

These concerns will be raised formally at the time of the MPR. However, if significant issues emerge before or after the MPR, the supervisor or trainee should discuss these with the relevant college visitor in a timely manner.

If, at any stage, the supervisor judges the trainee's performance to be on the borderline of failure, then they must inform College via the relevant college visitor. Any trainee who is at risk of failing a placement should be told as early as possible and given the opportunity to discuss and address the supervisor's concerns.

It is bad practice to introduce new information regarding trainee progress at the time of the EPR. Only in cases where significant new information emerged very late in the placement would this usually be acceptable.

MID-PLACEMENT REVIEW (MPR)

The function of the MPR

MPRs serve a number of important functions deemed essential by the Committee on Training in Clinical Psychology (CTCP), which accredits courses for the BPS:

> 'All clinical placements should be visited by a member of the course team at least once during each placement to monitor the clinical experience and supervision provided and to help resolve any problems which may arise.'

The MPR has a dual role. It gives an opportunity for all parties to reflect on progress in a manner which should be facilitative, and in cases where there is no risk of placement failure, it is this aspect which will be to the fore. However, it also has a gatekeeping function, because it should identify issues which look likely to lead to placement failure – either because of problematic trainee performance or competence, or because of a failure of the placement to provide appropriate experience and/or supervision.

The MPR usually comprises:

- A formal review of the clinical work of the trainee in terms of content, level, the skills and competencies he/she has acquired.
- A formal review of the supervision arrangements to ensure that the placement contract and supervision guidelines are being followed.
- An opportunity to identify targets (clinical, supervisory or organisational) for the second half of the placement.

Although there may be exceptions, it should be the case that trainees who fail placements will have been alerted to this risk at the MPR, and will therefore have had the opportunity to improve their performance.

The Process of the MPR

Timing
The MPR should take place half way through the placement – reviews held later than this leave too little time to implement any essential recommendations.

> For October-April placements this means the review tales place in December-January. For April-October placements the review takes place in June-July.

The review usually takes between 1 and 1 ½ hours.

Because it is more efficient for college visitors to visit placements in the same locality on the same day, it is helpful if MPR dates can be set as early as possible. It is the trainee's responsibility to liaise between the MPR visitor and the supervisor.

Timing for one year placements
As above, for the purposes of the Examination Board one-year placements consist of two six-month placement periods. This means that each part requires a Mid-Placement Review and an End of Placement Review.

The first MPR will be around December-January, and the second around June-July. Both MPRs will usually be conducted on-site. However, if all is proceeding well at the first MPR, there are no substantive changes to clinical activity or placement organisation, and independent contact with supervisor and trainee confirms that the placement continues to function well, the second MPR may be conducted by telephone or video conferencing.

Structure of the MPR visit
Section 13 gives specific details of the structure and content of the MPR.

Briefly, the college visitor will outline the aims of the meeting and structure it appropriately. It is a BPS requirement that the trainee and supervisor are seen separately, followed by a joint meeting to give feedback and to agree any targets and 'action points'. This sequence is intended to maximise the opportunity for independent and accurate feedback, and though each of these meetings is confidential, it is usual for important areas of concern to be raised in the joint meeting.

In the meeting with the trainee, the college visitor will review their work and current placement and supervisory experience (with reference to the MPR-EPR form), and agree topics for discussion with the supervisor. In the meeting with the supervisor, the work of the trainee will be discussed (with reference to the MPR-EPR form), and again agreement reached about what should be discussed jointly. In the joint meeting the college visitor, trainee and supervisor will set targets for the remainder of the placement.

After the meeting, the college visitor will record on the MPR-EPR form the agreed targets for the remainder of the placement, as well as any additional issues raised in the MPR, which were not detailed by trainee or supervisor in their completed sections of the form prior to the MPR meeting. A copy is sent to the trainee and supervisor, and a copy retained at college.

THE END OF PLACEMENT REVIEW (EPR)

Function of the EPR

The EPR meeting is an opportunity for giving formal feedback about the clinical skills and competencies of the trainee and for evaluating progress on the placement. It comprises:

- A formal review of the trainee’s clinical work in terms of content, level, the skills and competencies they have acquired, with reference to updated ratings and feedback given on the MPR-EPR form;
- A formal review of the supervision, with reference to updated ratings and feedback given on the MPR-EPR form;
- An opportunity to identify targets for the next placement.

Process of the EPR

1) The EPR meeting should be scheduled so that it takes place at least one week before the end of the placement. An appropriate amount of time should be set aside - an hour and a half is probably about right, but longer may be required if there are a lot of issues to discuss.

2) **Before** the EPR meeting supervisors must have:

a) completed Parts B, D and E of the MPR-EPR form, and
b) sent a signed copy of the form to college (either posted as a hard copy or (preferably) emailed as a pdf (so that the form we receive includes the supervisor’s signature), and sent to placements-admin@ucl.ac.uk.

The rationale for submitting the MPR-EPR form with supervisor’s feedback completed to college before the EPR meeting is that the form is equivalent to an Examiner’s Report. As such it needs to be prepared and submitted independent of any subsequent discussion or feedback from trainees – as would be the case for any examined piece of work.

Before the EPR meeting, trainees must have:
c) completed Parts A and C of the MPR-EPR form.

3) The EPR meeting should start with the supervisor giving the trainee a copy of the MPR-EPR form with their feedback completed that has been submitted to college, and continue by discussing and reflecting on the formative and the summative feedback with the trainee.

4) After discussion of the supervisor’s feedback has been completed the trainee should give the supervisor a copy of the MPR-EPR form with their trainee feedback section completed (Part C).

In this way the trainee can give feedback on the placement without being concerned that this will influence the supervisor’s evaluation.

Trainee comment on supervisor feedback

Trainees can comment on the content of the supervisor’s feedback using the Trainee comments on supervisor feedback at EPR form, although this is not mandatory. However, they cannot request any revision or redrafting: as above, the supervisor’s feedback represents an independent, formal evaluation of their progress. The trainee comment form should be returned to college, along with other placement paperwork.

GIVING FEEDBACK IN SUPERVISION, IN THE MPR AND IN THE EPR

Gatekeeping and facilitation

Feedback serves two purposes. It indicates whether the trainee is at the right level for their stage of training, and whether there are any concerns which may lead to overall placement failure. This 'gatekeeping' aspect of feedback is critical, but contrasts with the more detailed feedback which trainees should be receiving about their capacity to deliver specific competencies.

It is important for trainees to receive both types of feedback; they will be more responsive to constructive feedback about specific areas of functioning if they are clear that their overall performance is satisfactory. Equally, trainees who are at risk of failing a placement need to know this, and to know in what ways they are failing. However, it needs to be recognised that this can place the supervisory relationship under some strain, because the supervisor's evaluative role is made more explicit. This fact needs to be acknowledged and (if necessary) appropriate professional support sought by both parties. Without this, supervisors risk becoming unduly concerned about further upsetting the trainee (and so withholding important feedback), and the trainee risks being caught in a cycle of undue anxiety about monitoring of their performance (thereby reducing their effectiveness still further).

The nature of feedback at the MPR

Mid-placement qualitative feedback is essential both for the trainee and for the supervisor. Feedback should give trainees a clear sense of their overall development and supervisors an indication of the degree to which the placement is achieving its aims; for both parties the MPR should indicate strengths as well as any areas for change and improvement.

The placement visitor has an important role in shaping the review and ensuring that it is a productive, useful discussion, rather than merely a brief check that all is well. Feedback should be detailed, constructive and designed to help the trainee to improve; wherever possible it should be behaviourally specific. The MPR-EPR form helps support supervisors and trainees to structure the discussion.

The process of feedback is of course two-way. Feedback about the placement and the quality of supervision should also be provided by the trainee. The trainee feedback section of the MPR-EPR form can be used to help structure the feedback.

Raising concerns about placements prior or subsequent to the MPR

Though the MPR is the formal setting for evaluating and discussing how a placement is progressing, trainees and supervisors should always feel free to contact the college visitor at any point in the placement cycle if they have serious concerns (either before or after the MPR).

The nature of feedback in the EPR
In an ideal world the EPR should contain no surprises; the MPR should have given the trainee information about their strengths and weaknesses, and the supervisor will know the good and bad points about the placement. This ideal is not always achieved, and the following points should be taken into account to ensure that the Review is a positive and constructive experience for both parties.

The supervisor's feedback section of the MPR-EPR Form (Part D) has space for supervisors to make detailed comments on a range of clinical competencies; this feedback should be discussed with the trainee at the Review and strengths and needs clearly identified. Feedback should be detailed and constructive, wherever possible behaviourally specific, and designed to help the trainee improve his/her performance. As above, supervisors (as good psychologists) should avoid a situation in which they are providing totally negative criticism, since this does not encourage or guide trainees to develop a range of effective and appropriate skills. The supervisor should try to set aside positive or negative personal feelings about trainees when making evaluations.

The trainee's feedback section of the MPR-EPR Form (Part C) lists a variety of qualitative and quantitative features of the placement and the supervision. It is important to discuss feedback about the placement only after the clinical feedback has been given; this ensures that trainees are not threatened by the risk that their criticisms will affect the quality of the feedback about their own performance.

Clearly, feedback is only useful to the extent that it can be heard and acted upon. Under some circumstances the decision to remain silent may be wise. However, in these cases the matter will usually be discussed with the relevant course visitor.

Bias in feedback
As good psychologists we should be alert to the risks of skewing feedback, especially when the judgements being made relate to complex tasks. From observation we know that there are some risks which are worth guarding against:

For supervisors:
a) Only focusing on the positive, and avoiding any reference to negative issues. This 'cult of the positive' can arise under a range of circumstances. Ironically it can occur because the trainee is performing very well overall, and supervisors find it hard to give detailed comments on specific aspects of performance. However, it also arises when supervisors are reluctant to draw attention to areas which they find hard to raise with trainees. An example would be a very anxious trainee, where supervisors worry that raising their concerns about clinical work would exacerbate anxiety and further diminish performance.

b) Only focussing on the negative, and finding it difficult to find positive aspects of the trainees work. It is worth reflecting on the fact that it is unlikely that any trainee performs so badly that there is nothing they do right. This sort of bias can begin to emerge when trainees fail to achieve an appropriate level of functioning, and do not respond to supervisory input. In these cases it may be that more attention needs to be paid to what the trainee can do, rather than what they can't. However, because rational appraisal can sometimes be difficult when supervisors become frustrated by a lack of progress, an entirely negative appraisal should give rise to self-examination on the part of the supervisor.

For trainees:
Trainees may feel disinclined to discuss negative placement feedback with the supervisor, and might be particularly concerned about this being written down in a formal report (i.e. the MPR-EPR form).

This usually happens because they are anxious that disclosing their concerns will result in a negative evaluation. For example, they may feel that the supervisor is inclined to judge them negatively, and do not wish to exacerbate this by complaining. Equally they may have (legitimate) personal feelings towards the supervisor or the setting which they fear disclosing in case they are seen as being unprofessional.

Though the power imbalance inherent in training makes it harder for trainees to feel confident about giving feedback, it is important that they contribute to monitoring, and that their views are heard. However, it is recognised that this ideal may prove difficult under some circumstances, and that trainees may wish to report some concerns to a member of college verbally rather than in writing.

A summary of tips for good practice

- Both parties should prepare in advance the feedback to be given. Specifically supervisors and trainees should complete their relevant parts of the MPR-EPR form in advance of the EPR meeting. As noted above, supervisors should send their version of the form, completed and signed, to the course in advance of the EPR meeting. In the meeting, supervisors and trainees use the MPR-EPR ratings from the MPR-EPR form as a guide, but the feedback should be communicated in person at the time of the EPR.

- Feedback should be operationalised, positive as well as constructively critical and illustrated with examples.

- Supervisors and trainees should indicate the means by which clinical competence and the placement respectively might be strengthened.

- Both parties should avoid making global or unsubstantiated criticisms, or general comments on personality. Behavioural specificity is almost always more useful.

- Both parties should avoid presenting only the positive aspects of performance of the placement.

- Feedback about clinical performance should combine both positive and negative information and should ideally be communicated in the context of a good, supportive supervisory relationship. The better this relationship is, the more likely will feedback be listened to and subsequently acted upon. If supervisors or trainees are in any doubt about how to give feedback or what to say, or if they have doubts about whether the placement should be passed or failed, they should contact the MPR visitor for help.

- Supervisors and trainees should be familiar with the guidelines on passing and failing placements and the associated complaints procedures.

SECTION 13: CONTENT OF THE MID-PLACEMENT REVIEW (MPR) INTERVIEW

This section describes the sort of questions and issues, which will be raised by the college visitor. Because the visitor follows a set structure and is guided by the MPR-EPR form sections, it will be helpful for supervisors and trainees to have a sense of the format and content of the visit.

Overall focus of the MPR

The MPR has a summative function (it should establish whether the trainee is likely to pass the placement or to be referred to the Examination Board), but usually the main focus is to encourage formative feedback to both trainee and supervisor. Broadly, it includes discussion of:

- the clinical experiences available to the trainee
- the trainee’s progress in the placement
- the quality of supervision

Supervisor and Trainee - preparation for the meeting

For UCL trainees there is one form to complete prior to the meeting:

- Supervisors complete PART B and D of the document
- Trainees complete PART A and C of the document

Please note, there are two versions of the form – one for 6 month placements and one for yearlong placements. Please use the form that is relevant for the length of the placement.

Supervisors and trainees complete their sections of the MPR-EPR form independently i.e. supervisors complete parts B and D in one version of the form, and trainees complete part A and C in another version of the form. They each then send their completed form to the MPR visitor **at least one week before the MPR meeting.** Before the visit, it is helpful for the supervisor and trainee to review progress to date, guided by the placement contract, the clinical log, the reflective practice log and their ratings in the MPR-EPR form (though they do not have to specifically share their ratings and comments with each other before the MPR meeting).

Format

Please refer to the “Instructions to College Visitors conducting MPRs” document for a brief overview of the MPR procedure and format. Below are additional details of the content of the meeting.

Prior to the MPR, the MPR visitor will review the completed MPR-EPR forms from trainee and supervisor and collate them into one. The MPR starts with a 3-way meeting with the college visitor, the trainee and the supervisor. This is a factual discussion based on the placement contract and on the trainee’s log, and is used to establish the range of clinical, professional and research experiences available to, and undertaken by, the trainee.

This meeting is followed by separate meetings between the trainee and the college visitor, and the supervisor and the college visitor. These meetings aim to identify the quality of the clinical work being undertaken, the clinical experience being gained, the learning taking place and the quality of supervision. The MPR-EPR form is reviewed and referred to during these meetings.

Initial three-way meeting

As well as gaining an overall sense of the work being undertaken and basic placement arrangements, the visitor will check that the casework is appropriate (right amount, a good range, and preferably some diversity in relation to a range of demographics). They will also ask about arrangements for modelling, joint working and for direct observation/recording of the trainee's work by the supervisor and any other relevant professionals.

Meeting with the trainee

The visitor will ask how the placement is progressing in general before asking some specific questions about each area of the trainee section of the MPR-EPR form (Part C). This includes:

- Is the placement contract being fulfilled?
- Is the workload/caseload range and amount felt to be appropriate?
- Is supervision appropriately targeted to the placement aims and objectives, and is it of good quality? For example:
    - is it regular and what is the supervisor's availability
    - does it include case-review?
    - does it include specific theory-practice links and formulation?
    - does it include reflection on casework and discussion of general issues arising from the work?
    - how are session recordings or live observation integrated into supervision?
    - does it include discussion of overall progress personal/professional issues
    - does it offer general support?
- Has the trainee had the opportunity to work with service users as consultants? (see section 10 of the handbook)
- Has the trainee had the opportunity to conduct an inter-professional learning exercise? (see section 10 of the handbook)
- Is the professional context conducive to training? Are there any aspects of the placement that the trainee is finding stressful?
- Are there any specific concerns that the trainee has about the supervisor or the placement?
- What feedback has the trainee had from the supervisor?
- Is there anything the trainee would like to change, or to have done differently?
- What targets would the trainee identify for the remainder of the placement?

Meeting with the supervisor

The visitor will ask how the placement is progressing in general (including a check on whether there has been appropriate support from the course and any comment on the relationship between the course and the placement) before asking some specific questions about each area of competence the supervisor rated on the form (Part D). This includes:

Basic clinical competencies: what progress is the trainee making in the following areas:

- assessment, which includes engagement and interviewing skills
- formulation and a capacity to make theory-practice links on the basis of assessment/ ongoing work
- capacity to make an intervention which is informed / guided by a formulation
- capacity to evaluate their work, both informally (e.g. estimating progress in relation to session material) as well as formally (using formal measures)
- ability to report on their work, both verbally and in writing

Areas of clinical competence specific to the placement
Questions will reflect the nature of the placement and the aims and objectives set out by the placement contract

Clinical/ Professional competencies:
Can the trainee:

- think about and understand client's needs?
- comprehend complex clinical contexts without becoming overwhelmed?
- manage their anxiety about clinical and professional work in an appropriate manner?

Professional skills: Can the trainee:

- behave in a manner congruent with usual expected professional standards?
- manage and negotiate boundaries?
- act at an appropriate level of autonomy, given their stage of training?
- take and follow through decisions
- demonstrate an appropriate level of resilience in professional contexts?
- use of client feedback to reflect on and develop their clinical practice?

Professional and ethical standards
Does the trainee act in a manner which is congruent with expected professional and ethical standards?

Working with colleagues Does the trainee:

- demonstrate an appropriate repertoire of professional skills?
- have the capacity to work well and effectively with colleagues and other professionals?
- Has the supervisor asked colleagues for feedback and what was it?

Use of supervision, evidence of learning from supervision and of independent learning

Does the trainee:

- prepare for supervision, and make an active contribution to it?
- listen and respond to feedback?
- have a capacity for reflection and for reflective practice
- have a capacity to think reflexively, take on board feedback and show evidence of change on the basis of this feedback?
- show evidence of applying learning from supervision in subsequent clinical sessions?
- think critically and creatively?

Overall

Is there evidence that the trainee is making progress and showing evidence of learning?

- What targets need to be set for the remainder of the placement – what is going well, what needs to be focused on, and if targets are identified are there any areas which are being flagged as areas of clear underperformance?
- Are there any specific concerns that would not lead to overall placement failure, but should be noted?
- Does the supervisor anticipate the trainee passing – are there **any** areas of concern that could give rise to possible failure?

Final joint meeting with the trainee and the supervisor

The idea of this meeting is to give feedback from both separate meetings, so the visitor will summarise the trainee's appraisal of the placement and supervision, and the supervisor's assessment of the trainee's performance to this point.

Identified targets for the remainder of the placement will be detailed and discussed in order to ensure that all parties are clear about these and have had the opportunity to agree on how they will be taken forward.

If a risk of placement failure has been signaled this will be explicitly discussed in this meeting.

Written report

The visitor will record the agreed goals on the MPR-EPR form, as well as any additional issues / concerns that were raised in the meeting, but that had not been noted in detail by either the trainee or supervisor in their sections of the form. Where there are these additional issues, they are recorded in the Appendix section of the MPR-EPR form. A copy of this completed form is sent back to the trainee and supervisor. This will usually be emailed within 2 weeks of the visit. If there are factual errors in the form, trainee and supervisor should identify these as quickly as possible. The completed and agreed form should then be uploaded to ETFS by the trainee under the "MPR Report" section for that placement.

SECTION 14:
OVERVIEW OF PLACEMENT FEEDBACK FORMS FOR SUPERVISORS AND TRAINEES

This section gives an overview of the forms used by trainees and supervisors at various points in the placement cycle. All these forms are downloadable from the Course website.

"UCL DClinPsy MPR-EPR form"

This form is used by both supervisors and trainees to monitor progress and quality of the placement. The form is used initially at MPR and is then updated at the point of EPR.

At MPR:
- Trainees complete Parts A and C
- Supervisors complete Part B and D. If the placement is shared between two supervisors, they complete these parts jointly indicating whose comments are whose.

At EPR:
- Trainees update Parts A and C
- Supervisors update Parts B, D and complete Part E. If the placement is shared between two supervisors, they complete these parts jointly indicating whose comments are whose.

Please note, there are two versions of this form:
- "UCL DClinPsy MPR-EPR form for a 6 month placement": to be used on 6-month placements
- "UCL DClinPsy MPR-EPR form for a yearlong placement": to be used on yearlong placements

"UCL DClinPsy Trainee progression concerns form"

If serious concerns about trainee progress emerge at the Mid-Placement Review (or indeed at other points in the placement cycle) the MPR visitor and supervisor will document these in the MPR-EPR Form. However, the supervisor also needs to formally signal their concerns to the Course using this one-page form.

"UCL DClinPsy Trainee comments on supervisor feedback at EPR form"

Trainees cannot request any revision or redrafting of the supervisor's feedback in the MPR-EPR form as the supervisor's feedback represents an independent, formal evaluation of their progress. Trainees can however comment on the content of the supervisor's feedback at EPR using this form, although this is not mandatory.

"UCL DClinPsy form for interim feedback from supervisors of third year trainees in their final placement"

The main Examination Board (at which final decisions about passing or failing are made) meets in early September, slightly ahead of the point at which trainees complete the course (which is at the end of September). The Board needs a formal indication of trainee progress on placement, but at this point the MPR-EPR form will not have been completed. To resolve this, the 'interim' form is a one-page form which simply asks supervisors to indicate whether the trainee is expected to pass the placement.

SECTION 15: END OF PLACEMENT REVIEW

GUIDE TO COMPLETING THE MPR-EPR FORM AT THE POINT OF EPR

At the end of each placement period there is an end of placement review. Trainees and supervisors complete the relevant sections of the MPR-EPR form to give feedback to the trainee, the supervisor and the placement.

SUPERVISOR'S FEEDBACK IN THE MPR-EPR FORM

There are three Parts of the MPR-EPR from which supervisors complete at the point of EPR:

Part B This section is concerned with the supervisor’s summary evaluation of the placement. It gives feedback to the Examination Board of the Course about whether the trainee has passed or failed the placement

Supervisors rate the trainee as “PASS” or “REFER TO EXAMINATION BOARD”. Guidelines as to the meaning of these terms are listed later in this document.

Part D This section is a report on how the trainee has progressed over the placement, and gives an opportunity for identifying the trainee's strengths and needs

Part E This section helps to maintain continuity of training between placements. It asks supervisors to indicate both the trainee’s strengths and areas for development. This section is passed to the trainee’s next supervisor.

The supervisor's rating constitutes advice to the Examination Board. As such, it is an important judgment. Although trainees cannot request any changes in a completed form, they can comment on it by completing the Trainee comments on supervisor feedback at EPR form, and may appeal against a decision of the Board of Examiners. Section 27 of the handbook contains the guidelines on appeals.

In the third year, supervisors would also complete a brief (one-page) form to give an ‘interim’ judgment of third-year trainees in their final placement. This is required because the final Examination Board meets in early September, before trainees have finished their placements and thus would have completed the EPR meeting. This quirk of timing means that the Board needs supervisors to indicate how the trainee is progressing, before the point at which the usual MPREPR form is completed. This form is available on the course website and should be submitted in late August of the final placement. Supervisors would have been informed of the actual deadline in the placement letter.

Supervisor’s recommendation to the Examination Board - PART B
Placements are rated as 'Pass' or 'Refer to Examination Board’. These ratings constitute advice to the Board of Examiners of the Course.

“Pass”
By passing the placement supervisors are indicating that the trainee has demonstrated clinical and professional competences relevant to the placement and to their stage of training (see Section 11 of the handbook for further details).

“Refer to Examination Board”
This category allows supervisors who have significant concerns about a trainee's performance to draw these to the attention of the course. The course will then make a decision about whether the placement should be passed or failed.

This rating is used when there is evidence of serious, persistent shortcomings in any of the areas covered by the supervisor’s feedback form. Examples could include:

- failure to demonstrate acceptable levels of clinical and/or professional competence judged in the context of the stage of training and the opportunities provided by the placement
- serious lack of sensitivity and responsiveness to client's and/or colleague's communications
- serious and persistent difficulty in an important area of clinical-professional functioning (for example, being unable to formulate casework at a level appropriate to the stage of training)
- failure to show learning or to develop skills over the course of the placement
- failure to complete a sufficient amount of work (which is not accounted for by a lack of opportunity, or by illness)
- professional misconduct or serious breaches of the BPS Code of Conduct

It is important that concerns about poor performance on a particular item or set of items have been discussed with the trainee prior to the end of placement review. Where these concerns have become evident in the first part of the placement they should have been discussed at the Mid Placement Review, and with the trainee’s course tutor.

The Board of Examiners, which has an overview of the trainee's development, will consider a number of sources of evidence in order to reach a decision about the appropriate outcome. These are:

a) the supervisor’s feedback at the end of placement in the MPR-EPR form
b) feedback from the mid-placement review in the MPR-EPR form
c) feedback from the trainee’s course tutor
d) evidence of progress from previous placements
e) the outcome of a clinical viva (see Section 27)

The Board can decide to fail the placement, to pass it conditional on stipulated requirements to demonstrate specific competencies in the subsequent placement, or to pass the placement without further conditions.

Guidelines for Appeals against placement decisions are available from the Course and in Section 27 of the handbook.

Giving feedback - Part D
This part allows supervisors to give summative and detailed formative feedback about different areas of clinical competence. Each area contains exemplars, which help to anchor expectations relating to each area of activity.

It is not a requirement that the supervisor and the trainee agree about the feedback or the overall placement rating. However, it is important that supervisors discuss their feedback with the trainee, and that they have this discussion before the trainee gives their feedback about the placement.

Goals for the next placement - Part E
This part allows supervisors to identify specific goals to be carried forward to the next placement, should they feel that this is necessary or would be helpful.

Timescale for returning the MPR-EPR form with supervisor feedback completed
The MPR-EPR form is a critical part of the evaluation process, and must be returned as soon as is practical after the placement ends. Without the form, the Examination Board cannot ratify the trainee’s clinical experience, and hence significant delay in returning the form has the potential to jeopardise the trainee’s progress through the course.

TRAINEE'S FEEDBACK IN THE MPR-EPR FORM

Within the MPR-EPR form, there are two Parts which trainees complete:

- Part A: this section provides details of the placement itself including number of days completed on placement
- Part C: this is where trainees provide more detailed feedback on the placement. Trainees are asked to comment on each aspect of the placement, identifying any issues and providing suggested developments. The following areas are covered:
    1. **Basic placement organisation**
    2. **Placement monitoring**
    3. **Supervision**
    4. **Range of clinical experience**
    5. **Personal / professional support**
    6. **Personal and professional development**

AFTER THE EPR MEETING: THE MPR-EPR FORM

Following the EPR meeting where supervisor and trainee have talked through their feedback in the various sections of the MPR-EPR form, the trainee will amalgamate the supervisor version of the form with theirs and they will both sign the form. This complete version of the form is then uploaded to ETFS. Trainees will take this completed form to their next placement, showing their new supervisor Part E (at a minimum), but can provide them with the whole form to help plan their experiences / areas for development in the new placement.

SECTION 16: PORTFOLIO OF CLINICAL EXPERIENCE

Overview of content

Trainees maintain a portfolio of clinical experience that identifies the work they carry out in each placement. A separate Log of Clinical Experiences (i.e. Section A) should be completed for each placement. Sections B, C and D are cumulative records and are therefore updated at the end of each placement.

There are four sections to the portfolio:

Section A	Log of clinical experiences	A record of direct and indirect clinical and professional work
Section B	Competences in specific psychological therapies	A record of competences in CBT, psychodynamic or systemic therapies
Section C	Psychological testing competences	A record of competences in psychometric assessment and interpretation
Section D	Cumulative Training Record ('Reflective Practice Log')	A cumulative record of progress in relation to HCPC / BPS criteria

The portfolio is used by the Course and external assessors to check that trainees have undertaken an appropriate range of clinical experience. As such it is a critical record of training activity.

Overview of procedure

Electronic versions of the portfolio should be downloaded from the website, and the portfolio maintained in an electronic format. All relevant paperwork can be accessed in two areas of the course website:

- from the 'Clinical Placement' section, or
- from the 'Useful Forms' menu

The portfolio should be updated at least once a month to ensure that it is an accurate record of placement activity. Completing it any less frequently makes it likely that casework will be left off the record, or that the record itself will be inaccurate.

The portfolio is reviewed at the Mid-Placement Review (MPR), and it is the trainee's responsibility to make sure that it is available for the MPR visitor. The MPR visitor will use it to ensure that the caseload is at the right level, and that the placement is offering the right breadth of experience.

Preserving a record of the log

At the end of each placement:

- Please combine Section A of the portfolio for that specific placement with an updated cumulative training record (Sections B, C and D) into a single file and submit an electronic copy to the ETFS.
- Please ensure your supervisor signs-off the portfolio by completeing the 'Supervisor Authentication of Clinical Experiences' form. Please ask your supervisor to email a PDF of the signed form to college. You should then also upload a copy of this signed off form to ETFS. This form can be downloaded from the course website, in the same location as other paperwork for the portfolio.

Trainees must keep an electronic copy of the portfolio for their own records. They should also ensure it is kept beyond the end of training, because they may be required to produce evidence of their clinical experience when applying for further training or post-qualification accreditation.

SECTION A: LOG OF CLINICAL EXPERIENCES

The Log of Clinical Experiences serves several functions:

- it creates and maintains an accurate and detailed record of the direct and indirect work trainees have undertaken and the supervision they have received
- it can be used to identify gaps in experience or areas which need more focus
- it aids placement planning (for example, when reviewing progress in a current placement or thinking about the content of future placements)
- it can be used as evidence of clinical activity when seeking accreditation with external bodies (such as BABCP)

There are five parts to the log:

1. Work that the trainee has observed (e.g. work conducted by their supervisor, other psychologists or other professionals)
2. Work conducted jointly with the supervisor, other psychologists or other professionals
3. The trainee's independent work
4a Indirect and service-level work
4b Developing leadership competences
5. Portfolio of measures (Practice Based Evidence)

As can be seen from the examples which follow (a part completed log), the log is summary of the clients seen and their presenting problems, the work undertaken and the supervision received: the examples are intended as a guide to the level of detail required.

A separate Log of Clinical Experiences (i.e. Section A) should be completed for each six month placement. Trainees on a 12-month placement should complete one log covering the two six-month placement periods.

UCL Doctorate in Clinical Psychology - Clinical Log

Trainee name: Anne Smith

Supervisor(s): Gail Jones and James Turner

Placement & placement type: Placement 1: Secondary Care Psychology Service, Adult Mental health
Placement dates: 27rd October 2021 to 19th September 2022

1. Work that you have observed

Case no.	Demographics (e.g. gender, age, ethnicity)*	Referred by	Main problems	No. of sessions	What was observed? (Whom did you observe?)
1	Male 30, White UK	GP	Agoraphobia	3	1 assessment session, 2 CBT treatment sessions Observed supervisor (GJ)
2	Couple Male 32, Black Afro-Caribbean; Male – 35 – White European	Social worker	Relationship difficulties	5	Ongoing treatment sessions, using Behavioural Couples Therapy Observed supervisor (GJ)
3	Group Female 45 White UK; Female 32 White UK; Female 38 White European; Female 40 White UK	GP	Depression	3	CBT Group for people with low mood/depression Observed supervisor (JT)

If you are not sure about these details, please give your best guess

2. Joint casework with supervisor or other professionals

Details of supervisor(s) and/or co-workers

Supervisor/ co-worker name and profession	Supervisor/co-worker's qualifications & professional accreditation/ registration details (e.g. BPS, HPC)	Accreditation with psychological therapy bodies (e.g. BABCP), including registration details
Gail Jones	Clinical Psychologist HCPC Reg PYT32140	Accredited CBT therapist with BABCP

Number of supervision hours for each case

Case number	Supervisor (initials):	N^{o} of supervision sessions for this case	Cumulative supervision hours for this case
4	GJ	4	1

Case n^{o}.	Demographics (gender, age, ethnicity*)	Referred by	Main problems	Outline the intervention undertaken What did you do? What did your supervisor/ co-worker do?	Describe any formal evaluation procedures	N^{o} of sessions	Case complete or ongoing?
4	Female, 32, Bangladeshi	GP	Panic attacks	Two assessment sessions; supervisor took lead in first session, I led second session	BAI CORE	2	ongoing

If you are not sure about these details, please give your best guess

3. Independent Clinical Work

Supervision arrangements

Supervisor(s) name and profession	Supervisor's qualifications & professional accreditation/ registration details (e.g. BPS, HCPC)	Details of accreditation with psychological therapy bodies (including registration details) (e.g. BABCP)
Gail Jones	Clinical Psychologist, HCPC Reg PYT32140	Accredited CBT therapist with BABCP
James Turner	Clinical Psychologist, HCPC Reg PYT32142	N/A

Number of supervision hours for each case

Case number	Supervised by (initials):	Number of supervisions for this piece of work	Supervision hours for this piece of work
5	**GJ**	**16**	**4**
6	**JT**	**3**	**0.75**

Description of casework

Case nº.	Referred by	Demographic information (gender, age, ethnicity*)	Main problems	Outline the intervention undertaken, including main treatment modes and any relevant additional information (e.g. co-workers or shared case management)	Describe any formal evaluation procedures (more detail can be included in Section 5 of the portfolio). Client feedback form?	Was the work recorded/ observed ? If so, by whom and how?	Nº of sessions	Case complete or ongoing?

5	Psychiatrist	Female, 34, White, UK	Self-harm, eating disorder, alcohol misuse, personality difficulties	Assessed over 4 sessions using clinical interview Intervention: DBT and CBT	BDI, BAI, CORE, dysfunctional assumptions scale completed ever 4 sessions (hence pre and post) UCL client feedback form completed mid and end treatment	All sessions recorded and discussed in supervision	16	Completed
6	GP	Couple, male 27, female 24, both White European	Husband depressed Sexual difficulties (erectile dysfunction)	Assessed over two sessions Intervention: Behavioural couples therapy and sex therapy	Golombeck inventories (GRIMS, GRISS) Standard service feedback form given at start of intervention	All sessions recorded and discussed in supervision	4	Ongoing

4a. Indirect and service level work

AREAS OF WORK	***Brief description of each piece of work***	***Role taken***	***Estimate of duration****
Service related research	Audited demographics of inpatient referrals, contrasted against census data and fed-back results to team	Research and consultation	2 months (approx. 2 hours per week)

Other (specify)			
Other (specify)			

*** Please use the most appropriate metric – e.g. if the work took place over a number of days and over a long period then ‘days’ is the best unit; if your input is one-off and fairly brief then ‘hours’ may make more sense**

4b. Developing Leadership competences

AREAS OF WORK	*Brief description of each piece of work*	*Role taken*	*Estimate of duration**
Teaching			
Training			
Supervision	Supervised two nurses conducting exposure over 6 weeks Teaching for care home staff on risk management (with supervisor)	Supervision Teaching	6 hours
Consultancy			
Service user consultation projects	Two meetings with carer group to discuss their experience of support offered by the service; feedback this information to clinical team	Consultation	3 hours
Working within the organisation (multidisciplinary / inter-professional work)	Weekly MDT intake and assessment meetings (case review and allocation)	Active participation; chaired the meeting on two occasions	1.5 hours per week
Working across organisations (inter-agency liaison)	Liaison with local CMHT to support transfer from in-patient to community for three clients	Acted as case co-ordinator	Ongoing
Working with commissioners			
Grant funding			
Other leadership work (specify)			

*** Please use the most appropriate metric – e.g. if the work took place over a number of days and over a long period then 'days' is the best unit; if your input is one-off and fairly brief then 'hours' may make more sense**

5. Portfolio of Measures (Practice Based Evidence)

Case No.	**Main problems**	**Completed intervention? (Y/N)**	**Measures/Procedures used to evaluate client progress**	**Pre-post change on measures**	**Reliable change (R)? Clinically significant change (CSC)?**	**Interpretation of/comment on process/outcome**
5	OCD, Depression and Anxiety	Y	PHQ-9 GAD -7 OCI Questionnaire	PHQ-9 (Pre =19, post = 9) GAD-7 (Pre = 21, post = 11) OCI (Pre = 70, post = 50)	PHQ-9 R (Y) CSC (Y) GAD-7 R (Y) CSC (N) OCI R (N) CSC (N)	Client reported improvements mood and OCD symptoms. *High variability in norm samples for OCI makes the RCI very large.
6	Self-harm, Anxiety, Trauma,	N	PHQ-9 GAD -7 Impact of Events	PHQ-9 (Pre =19, post = 7) GAD-7 (Pre = 17, post = 15) IES (Pre = 2.7, post = 1.8)	PHQ-9 R (Y) CSC (Y) GAD-7 R (N) CSC (N) IES R (Y) CSC (N)	Client reports improvements in mood and less frequent intrusive memories, but continues to feel anxious.
7	Husband depressed Relationship difficulties	N	PHQ-9 Goal Attainment Scaling	PHQ-9 (Pre =19, post = 12) GAS (Pre = 4, post = 2)	PHQ-9 R (Y) CSC (N) N/A	Goal indexed by the GAS was to attend after work social events. Some progress made and mood a little better. Change reflects session 1-3, therapy still ongoing.

SECTION B: COMPETENCES IN SPECIFIC PSYCHOLOGICAL THERAPIES

The BPS requires trainees to maintain a record of their competence in specific psychological therapies, benchmarked against a recognised competence framework. This section of the log is based on the UCL competence frameworks (which can be accessed at www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm).

The accreditation criteria specify that trainees need to demonstrate their competence in CBT and at least one other therapy; reflecting this, competences for the three therapeutic approaches taught at UCL are set out in this section: CBT, Psychodynamic and Systemic therapies.

There are three parts to this section:

1. A rating of specific areas of competence – these are fairly high-level descriptions of activities associated with delivering the therapy competently, and are based on the competence 'maps' that underpin the UCL competence frameworks.

   At the end of each placement trainees and supervisors should jointly 'RAG' rate the trainee's level of competence in therapies that have been conducted, using the following scale*:

Red	Competence not demonstrated: many areas require development
Amber	Competence demonstrated well in some respects, but also some areas in need of development
Green	Competence demonstrated well - a few areas for development, but none significant

**Bear in mind that an area of competence will not necessarily progress from red through amber to green. The challenge of moving from one client group to another sometimes results in a competence previously ranked as 'green' moving to 'amber', reflecting the challenge of applying the skill in a new context.*

2. An indication of the client groups with whom the therapy has been conducted

3. An indication of the problem areas in which experience has been gained. The focus here is on your experience of working across problem areas. As such if a client presented with two substantive problem areas they should be 'double-counted').

<u>An example</u>

The example that follows is for CBT (the sections for psychodynamic and systemic work follow the same principles). It shows how competences acquired in each placements build up to form a cumulative record. As such all the sections need to be updated after each placement has been completed (where CBT has been used).

The trainee's placement pattern is as follows:

Placement 1 IAPT AMH - main model applied: CBT

Placement 2 AMH - main model applied: psychodynamic
Placement 3 Child - main model: applied: CBT
Placement 4 Older Adult - main model applied: CBT

This means they only complete this section of the log for placements 1, 3 and 4 (because these are the placements in which they used a CBT approach). If they undertake additional placements in which they gain CBT skills they would add further columns to the record.

Competences for Behavioural and Cognitive Therapies

Section 1 - This section identifies the broad areas of CBT competence that trainees should acquire over training. These are drawn from the UCL CBT competence framework, accessed at www.ucl.ac.uk/CORE/ The website contains an interactive map of the CBT competence framework, and details the specific skills involved in delivering CBT. As such the framework is the benchmark for appraisal, and should be consulted before filling in this log. At the end of each placement where the therapy has been used trainees and supervisors should jointly RAG rate each area of competence:

Red	Competence not demonstrated: many areas require development
Amber	Competence demonstrated well in some respects, but also some areas in need of development
Green	Competence demonstrated well - a few areas for development, but none significant

Basic CBT competences	**Placement1 : IAPT AMH**	**Placement 3: Child**	**Placement 4: Older adult**
Knowledge of basic principles of CBT	🟧	🟧	🟩
Explaining and demonstrating rationale for CBT to client	🟩	🟧	🟩
Agreeing goals for the intervention	🟩	🟩	🟩
Structuring sessions and sharing responsibility for sessions structure and content (e.g. agreeing an agenda, reviewing practice assignments)	🟩	🟩	🟩
Identifying and discussing maintenance cycles	🟧	🟧	🟩
Problem solving	🟥	🟧	🟩
Ending therapy in a planned manner	🟥	🟥	🟩
Using measures	🟩	🟧	🟧

Overarching CBT competences			
Using guided discovery and Socratic questioning	🟧	🟧	🟧
Developing a collaborative formulation and using this to plan interventions	🟥	🟥	🟧

Specific behavioural and cognitive therapy techniques			
Exposure	🟧	🟩	🟩
Applied relaxation	🟧	🟩	🟩
Activity monitoring	🟥	🟩	🟩
Working with safety behaviours	🟧	🟧	🟧
Working with cognitions (eliciting and working with automatic thoughts & beliefs)	🟩	🟥	🟧
Working with imagery	🟥	🟥	🟧
Planning and conducting behavioural experiments	🟧	🟩	🟩

Section 2 – Client groups with whom CBT has been applied

Client groups	Placement context	Number of cases
Adults	IAPT service Outpatient psychological therapies service	9 clients 2 clients
Older Adults	Outpatient service Carers of people with dementia	7 clients 4 clients
Children and Adolescents	Outpatient service	9 clients
People with Intellectual Disability		
Other (specify)		
Other (specify)		

Section 3 – Problem areas where CBT has been applied

Specific focus of CBT interventions	Number of cases
Anxiety (phobia / social phobia / GAD / panic)	9
OCD	5
PTSD	3
Depression	6
Eating disorders	2
Personality Disorder	3
CBT for psychosis	
Family interventions for psychosis	
Addictive behaviours	2
Physical health presentations	1
OTHER (please specify)	
OTHER (please specify)	

Section C: Psychological Testing Competencies

This is a record of experience in psychological testing – essentially skills in using psychometric instruments and tests in order to identify and quantify suspected organic and functional deficits or problems.

This section is completed jointly by the trainee and the supervisor:

- The trainee maintains a basic record of the tests and instruments that they have used.

- The supervisor signs-off each assessment (identifying whether the right instrument(s) were selected, whether tests were administered correctly, whether the results were interpreted appropriately and appropriate feedback given to the client and whether the results were appropriately communicated to other professional colleagues).

The following example shows the level of detail that is required.

Section C: Psychological Testing Competencies

Details of supervisor(s) and/or co-workers

Supervisor/ co-worker name and profession	Supervisor/co-worker's qualifications & professional accreditation/ registration details (e.g. BPS, HCPC)	Accreditation/ training relevant to testing competences
Gail Jones	Clinical Psychologist HCPC Reg PYT32140	Approved QiCN clinical supervisor

Observation of tests administered by an appropriately qualified practitioner

Reason for assessment – what were the issues the assessment aimed to clarify	Client age	Specific tests/ instruments employed in the assessment	Person conducting the test

Tests administered by the trainee

Reason for assessment – what were the issues the assessment aimed to clarify?	Client age	Specific tests/ instruments employed in the assessment	Specify to whom, and how, feedback was given (including to client, carers and other professionals)	Supervisor validation Comment If any problems in any of the following areas: test selection administration interpretation feedback to clients and/ or carers feedback/formal report to other professionals	Supervisor Signature
Query diagnosis of dementia	82	WTAR RBANS WMS – IV DKEFS trails Fronto temporal Rating Scale	Feedback of diagnosis to client, other health services involved.	Supervisor decided test selection; appropriate administration, interpretation and feedback	
Rehabilitation planning for a woman with TBI	41	BADS WAIS - IV RBMT	Feedback of results to client and to rehabilitation staff involved in client	Appropriate in all areas	

Adapting therapy to take account of mild learning disability	38	WAIS – IV	Integration of results into formulation and feedback to client and family		Appropriate in all areas, feedback given jointly with supervisor	

Section D: Cumulative Training Record (Reflective Practice Log)

The Cumulative Training Record is intended to identify progression across the whole programme, benchmarked against the accreditation criteria used by the HCPC and the BPS. Rather than presenting this as a set of 'tick-boxes' the record is based on a map of the criteria which the trainee RAG-rates, using information from other sections of the log to help them reflect on the areas of work they have undertaken, and the skills they have developed.

The record is intended to:

- help trainees appraise their own progress, by contrasting the knowledge and skills they have acquired to date with the competences identified by the BPS and the HCPC in the accreditation criteria for courses (set out in other sections of this handbook).
- encourage trainees to reflect on their overall development, and in so doing contribute to the development of their capacity to operate as a self-reflective practitioner (in itself an important professional competence).
- help trainees to appraise their current strengths and needs, and to identify any specific training requirements or targets.

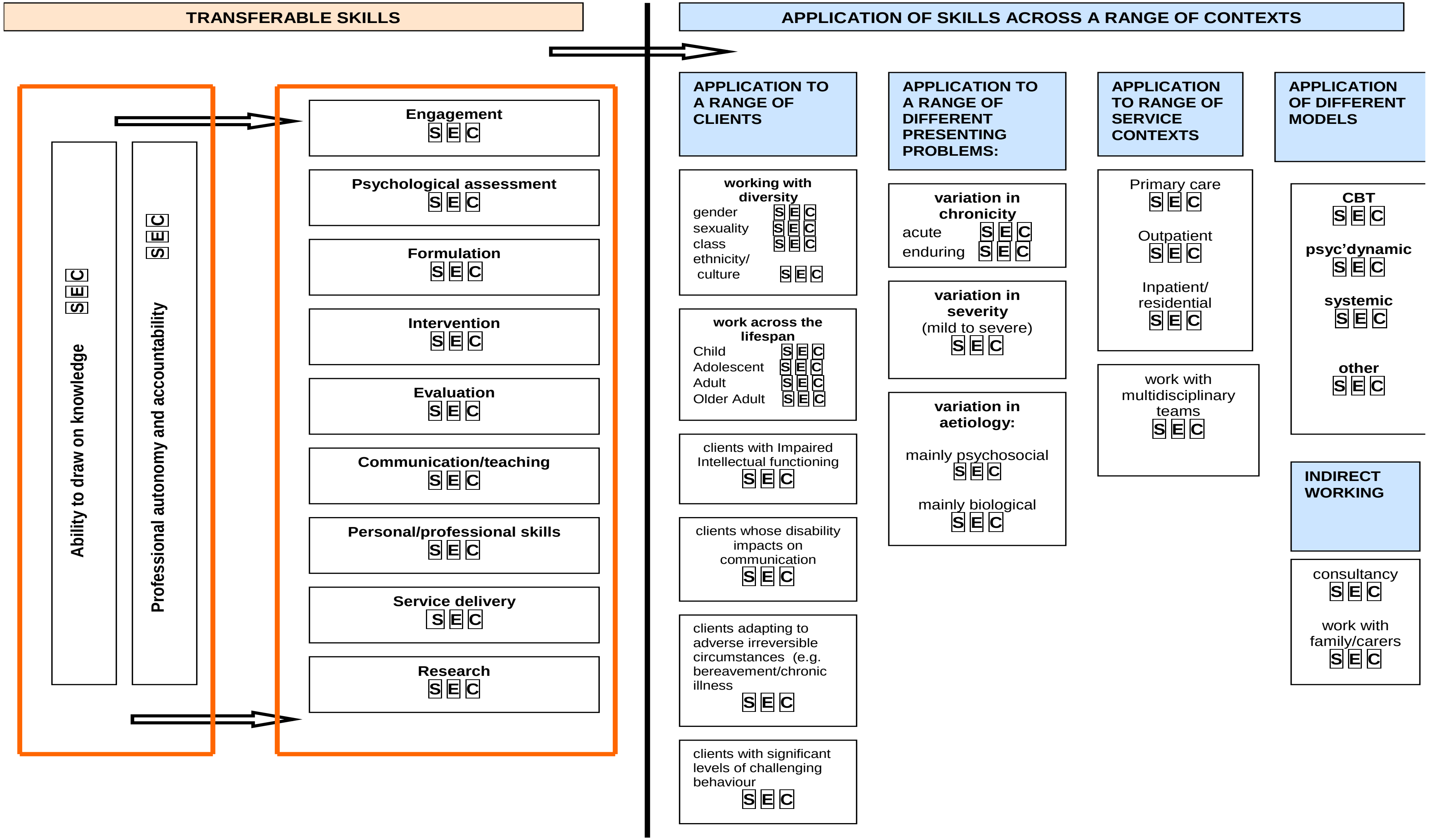
Format of the cumulative record

The format is shown below. It is best seen as a map, showing the competences which need to be acquired through training using a simple visual format which clusters sets of competences together.

The map needs to be viewed on the course website at Placement Monitoring and Paperwork | UCL Doctorate In Clinical Psychology - UCL – University College London, under the 'Clinical Portfolio' tab. Each 'box' in the map is a "headline" that describes an area of competence; placing the cursor on each box takes the reader to a page (or pages) that details the skills required to deliver each area of activity effectively.

The left hand columns of the map identify the sets of "transferable skills" that are used in almost every intervention. The rest of the template sets out the range of contexts in which these competences need to be demonstrated (e.g. variation in client, variation in problem, variation in theoretical orientation and service delivery).

Cumulative training record



TRANSFERABLE SKILLS

Ability to draw on knowledge S E C

Professional autonomy and accountability S E C

Engagement S E C

Psychological assessment S E C

Formulation S E C

Intervention S E C

Evaluation S E C

Communication/teaching S E C

Personal/professional skills S E C

Service delivery S E C

Research S E C

APPLICATION OF SKILLS ACROSS A RANGE OF CONTEXTS

APPLICATION TO A RANGE OF CLIENTS

working with diversity
gender S E C
sexuality S E C
class S E C
ethnicity/ culture S E C

work across the lifespan
Child S E C
Adolescent S E C
Adult S E C
Older Adult S E C

clients with Impaired Intellectual functioning S E C

clients whose disability impacts on communication S E C

clients adapting to adverse irreversible circumstances (e.g. bereavement/chronic illness S E C

clients with significant levels of challenging behaviour S E C

APPLICATION TO A RANGE OF DIFFERENT PRESENTING PROBLEMS:

variation in chronicity
acute S E C
enduring S E C

variation in severity
(mild to severe) S E C

variation in aetiology:
mainly psychosocial S E C
mainly biological S E C

APPLICATION TO RANGE OF SERVICE CONTEXTS

Primary care S E C
Outpatient S E C
Inpatient/ residential S E C

work with multidisciplinary teams S E C

APPLICATION OF DIFFERENT MODELS

CBT S E C
psyc'dynamic S E C
systemic S E C
other S E C

INDIRECT WORKING

consultancy S E C
work with family/carers S E C

Instructions for completing the Cumulative Training Record

1) Trainees should start by referring to the “master template” on the web and follow the hyperlinks to benchmark the range of skills that constitute each area of competence or activity. The value of consulting these hyperlinked pages is that they give the level of detail that trainees need to make judgments about their development in a more nuanced (and hence more accurate) manner.

2) Taking each section of the template in turn, trainees should reflect on their current level of competence. The reference point is the level of skill which a person would be expected to have at the *end* of training, rather than their *current* stage of training (This is because the competences in the log are based on the criteria used to judge whether a newly qualified psychologist can apply for registration with the HCPC,)

3) Trainees should download (and work from) an electronic WORD copy of the map and colour-code each area using the RAG ratings described below. This generates a simple visual summary of progress which makes it possible to identify progress and to spot gaps.

Trainees should RAG-rate themselves in relation to three criteria:

1. Their level of **Skill** **[marked S on the template]**
2. Their level of **Experience** **[marked E on the template]**
3. Their C**onfidence** in applying the skill **[marked C on the template]**

These are distinct – but in practice linked - ways of thinking about competence and are described further below

Using a RAG rating to track development

Skills

Self-ratings of skill level are influenced by all sorts of subjective factors and are biased by levels of self-confidence and self-critical tendencies (hence the advice above to use the hyperlinked pages to benchmark the expected skill-level).

Red	can apply none or very few of the relevant skills in practice, and/or find it difficult to put theoretical knowledge into practice
Amber	can apply some (but not all) of the required skills; starting to put theoretical knowledge into practice
Green	able to demonstrate the majority of relevant skills and to do so fairly fluently and consistently

Experience of a competence or of an area of work

There will always be debate about how much experience is enough, but the essential issue is whether there been enough experience of/exposure to the skill or the area, and hence opportunity to practise the skill.

Red	very little or no experience
Amber	some - but limited – opportunities for practising the relevant skills
Green	extensive opportunities for practising the relevant skills

Confidence

Ratings of confidence are inevitably subjective, based as they are on self-appraisal, something that may or may not accurately reflect ‘reality’ (as represented by external appraisal).

Red	no or little confidence of ability in applying this area of skill
Amber	some/ growing confidence, based on attempts to practise this area of skill
Green	fairly or very confident, based on a realistic awareness of strengths and weaknesses in applying this area of skill

As training progresses each trainee's 'map' should shift from being mostly red/amber to mostly green, but it is important to note that even final year trainees will not have a completely green competency map.

Reflecting on competence ratings

Appraising skills and competence level is more than a simple judgment. For example, "working across different client contexts" is not just about having worked with an older adult, a child or a client from a BME background. It is more about your ability to think both broadly and deeply about each area and about how these differences impact on your work.

By way of example, consider a trainee reflecting on their competence in working with older adults. The basis for a green' rating for skills, experience and confidence would be a capacity to reflect on how age impacts on their work in terms of each of the "iterative" competencies:

> **Engagement** A range of background factors might need to be taken into account – for example, the fact that clients will be older than the trainee, or that older people might have very different understandings of the nature of mental health and of mental health professionals, having grown up in an era of psychiatric hospitals.
> **Assessment** There may be some common themes or issues in this area to which psychologists need to be alert. One example to hold in mind is issues around transitions – for example, retirement, loss of a spouse, hospitalisation, the possibility of cognitive impairment or of physical conditions
> **Formulation** Formulations need to consider the impact of age - for example how the transition to retirement affects a person's longstanding core beliefs about their lack of worth, or the ways in which physical disability has made someone reluctantly dependent on their partner
> **Intervention** These need to be appropriately adapted to meet the needs of older people – for example, to someone with a cognitive impairment, physical disability, or a very different understanding of the meaning of psychological interventions.
> **Evaluation** There may be areas where monitoring and evaluation need to be adapted - for example the BDI is not a good instrument for evaluating the level of depression in older people, and the HADS or GDS are preferred.

Schedule for completing the cumulative record

The cumulative record should be completed so as to coincide with (and contribute to) key points of formal review:

> **Before Developmental Reviews -** to help trainees reflect on their development and progress through the course
>
> **At the End of Placement Review -** to review the learning and development that has taken place over the placement
>
> **In conjunction with placement planning questionnaires -** to aid discussions about training needs, helping to ensure that trainees are matched to the most appropriate placements.

SECTION 17:
THE RESEARCH COMPONENT: OVERVIEW

The research component of the DClinPsy has two parts: formal teaching and practical experience. This document gives an overview of each of these parts, and describes how they fit together over the three years of training.

Aims and objectives of the DClinPsy research component

Aims

The overall aim of the research component of the DClinPsy programme is to equip trainees with the research expertise necessary for practicing within an evidence-based profession. Specifically, it aims to give trainees the knowledge, skills and confidence to carry out and to appraise clinical research, evaluation and quality improvement (QI) studies.

The research component as a whole stresses the scientist-practitioner model, and the course encourages trainees to continue research, evaluation and QI as an integral part of their future professional roles. The course takes a pluralistic approach to research methodology, in particular valuing qualitative and quantitative methods equally.

Objectives

By the end of the DClinPsy course, trainees should:

1. Be familiar with the fundamental methods and concepts of clinical psychological research, including qualitative and quantitative methods, large-N experimental and quasi-experimental designs, small-N designs, secondary data approaches, the QI frameworks for service evaluation and audit, and ethics and research governance.
2. Be able to appraise published research studies.
3. Have acquired a grounding in the main methods of statistical analysis, and be able to use statistical software to carry them out.
4. Have conducted a service-related project in a clinical placement setting.
5. Have gained experience of the complete course of a major piece of rigorous scientific investigation, going through the stages of planning, execution, analysis and write-up.

Research teaching

The research teaching comprises subunits on research methods, statistics and project support.

Research methods teaching (in year 1, term 2) is based around a practical description of the research process, following the sequence of steps involved in executing a project: groundwork, measurement, design, analysis, interpretation and dissemination. Teaching covers the fundamental approaches to, and issues in, conducting clinical research (see the research methods subunit handbook for details). There is a Moodle course “TP: Research Methods” associated with this subunit.

Project support sessions (in years 1 to 3) focus on the practical aspects of undertaking the major research project. In the first year, project orientation introduces trainees to the wealth of research being conducted in UCL and the NHS region. There are also project clinics, in which staff advise trainees on their ideas for their projects. In the second and third years, the project support sessions focus on ethics and research governance, qualitative and quantitative analysis and writing up and presenting the thesis. There is a Moodle course “Research Project Support” associated with this subunit.

Statistics teaching (in year 2, terms 2 and 3) covers the basic statistical methods needed to carry out the major research project and to design, interpret and evaluate clinical research. It emphasises the importance of theory, methodology and clinical expertise in the appropriate use of statistics in clinical research. This subunit also has a Moodle course: “TP: Statistics.”

Practical experience in carrying out research projects

Trainees undertake two pieces of assessed research on the course: (1) the service-related project, usually conducted during one of the first two six-month clinical placement periods, and (2) the major research project, which is begun in the first year and continues for the remainder of the course. (See Sections 18 and 19 respectively of this handbook for details.)

Timetable

This timetable is a rough outline of the main milestones in the research component of the course. A detailed timetable for the major research project, including specific tasks such as data collection and analysis, is given in the section of this handbook on the Major Research Project.

Year One	
Term 1	Research-free zone
Term 2	Research methods teaching Project orientation and project clinics
Term 3	Statement of intent form due (date to be notified) Service-related project under way Research methods exam
Year Two	
Term 1	Research proposal due (date to be notified)
Term 2	Expenditure proposals due Ethics applications to be submitted Statistics teaching
Term 3	Statistics exam
Year Three	
Terms 1	Work on major research project continues throughout the year Submit literature review to supervisor
Term 3	Thesis handed in late June (date to be notified) Vivas and exam board in early September (date to be notified)

Further information

Detailed information on the research component of clinical training is given on the research section of the course website. The following two sections of this handbook describe the service-related project and the major research project.

SECTION 18: THE SERVICE-RELATED PROJECT

Aim

Service-related research is applied research that is (1) relevant to service provision and (2) undertaken within a clinical setting. The aim of the service-related project is to help trainees develop their research skills, including the ability to communicate research findings to clinical colleagues, and to give trainees experience in integrating research with clinical practice. Conducting practically oriented research is an important part of the clinical psychologist's professional role.

Competencies to be demonstrated

The service-related report allows trainees to demonstrate that they are able to plan, execute and write up a small-scale, applied research project within the constraints of a clinical setting.

What the markers will be looking for

The markers will want to see:

1. one or more clearly stated research questions relevant to clinical service provision,
2. a brief review of the theoretical or service-related literature that provides a the background to the research question(s),
3. a clear description of the methods,
4. a presentation of the results in an easily understandable form,
5. a discussion that relates the findings back to the research question(s) and to the literature,
6. a consideration of the strengths and limitations of the project,
7. clinical recommendations, based on the findings, with a statement about how the recommendations have been (or will be) fed back to the clinical service.

Timing and setting

The service-related project report is submitted instead of a clinical report. (The course requirement is a total of three clinical reports plus the service-related project report.) The work is carried out during placement time.

The project is normally completed during one of the first two six-month placement periods (i.e. during the first year of the course), and is submitted at the due date of Clinical Report 3 in the Autumn of the second year. Trainees should discuss the SRP with their clinical supervisor in the first placement; this will be reviewed in the first Mid-Placement Review.

Ideally, it is conducted in the trainee's current clinical placement setting, but if no suitable project is available there, it is also possible to do it in another clinical service – trainees should investigate linked services to which they may have ready access.

If, in unusual circumstances, there is not an opportunity to carry out the service-related project in the first year placement(s), then it can be carried out in a later placement period and submitted at the due date of Case Report 4, i.e. early in Year Three.

Topic and question

The research question must be service-related, that is, relevant to the planning, delivery or outcome of clinical (not necessarily clinical psychology) services. Usually, the project will have arisen out of the day-to-day work of the department in which the trainee is placed: clinical supervisors often have a wish-list of potentially useful projects that could be conducted in their service.

It is recommended that the trainee read the HQIP guidelines ‘A Guide to Quality Improvement Methods’ (June, 2015) to ensure that the project considers at least one of: clinical effectiveness, patient experience, and/or patient safety.

Some Trusts request that the projects fit with their QI (Quality Improvement) strategy and conform to the QI methodologies. The trainee and supervisor should consider if the QI project requested by the Trust relates in some way to the provision of psychological services, or if psychological factors are relevant to the study before agreeing a QI project with the Trust. In some Trusts, QI projects are registered with the R&D department, benefiting from formal support, and trainees are encouraged to use this option where available.

Some examples of past titles are:

- Do telephone reminders increase patient attendance at primary care psychological appointments?
- Service users’ experiences of an assessment clinic in a secondary care psychology service.
- Risk assessment documentation at a community mental health team: an audit and focus group.
- Implementing a clinical supervision group for cancer nurses: A preliminary analysis of nurses’ definitions, expectations, hopes and fears.
- Audit of provision of community leave in a Medium Secure Unit.
- A needs assessment for staff support following patient suicide.
- Client satisfaction with a locality mental health team for adults with severe and enduring mental illness.
- Audit of the referrals to the psychology section of a mentally disordered offenders’ team.

Training-focused projects

When, rarely, no service-based project is available, another option is to conduct a training-focused project, in which the training/workforce system is the “service” to be evaluated. Such projects could be focused, for example, on equality, diversity and inclusion. This option should first be discussed with the trainee’s tutor. A database is maintained by the course of potential projects of this nature. Such projects must adhere to the principles of an SRP in terms of methodology, generate recommendations, and feed these back, e.g. to relevant DClinPsy or BPS committees.

Research methods and sample sizes

A range of research methods can potentially be used, as appropriate to the research question: these are covered in the research methods lectures. Some possible research designs are listed below.

One frequently asked question is what the sample size should be. There is no hard and fast rule – considerations of statistical power, which are important in the major research project, can be relaxed. Service-related research is commonly exploratory rather than hypothesis testing.

For each type of design, we offer suggestions about adequate sample size based on the kinds of analyses that are likely to be conducted. These are rules of thumb, not rigid requirements.

- *Service audit*. The researcher does a descriptive audit of an established service, for example to look at how long clients have to wait after a referral, and whether this varies with the type of problem or the source of referral. This usually involves a retrospective examination of case notes or a database. The suggested N is 50. There may be a problem with missing data, so the N may need to be larger.

- *Client satisfaction with a service already received*. The researcher surveys clients about a service or intervention that has ended, often including some existing instruments (e.g. the Client Satisfaction Questionnaire), and may also correlate satisfaction scores with other client variables, e.g. ethnicity. Reports merely presenting descriptive client satisfaction scores are not usually adequate. The suggested N is 20 or more. An alternative is to examine clients' views of the service via qualitative interviews (see below).

- *Needs assessment*. Similar to the client satisfaction survey. The researcher assesses the psychological needs of potential clients for a service. The suggested N is again 20 or more.

- *Service comparison*. The researcher compares the clients of service X with those of service Y, on demographic and psychological variables. The suggested minimum N is 25 in each group.

- *Treatment outcome using pre- and post-intervention measures*. The researcher gives outcome measures to clients before and after an intervention. The suggested N is 12 or more, if just pre-post measurement is used. However, there is often a major problem with attrition in this design: to have 12 clients post-intervention may require at least 15 or 20 to start with, and this sample size is usually unattainable for a service-related project. An alternative strategy is to use more intensive measurements, e.g., session-by-session measures of a client's problems, within a multiple single case design. These then could be examined on an individual basis. The suggested N for this latter option is around 6. If a multiple single case design is used for the service-related project, trainees should not also do the single case design as one of their optional case reports.

- *Qualitative studies*. One common type of qualitative service-related project is to examine users' or staff's views about some aspect of a clinical service. It is acceptable to conduct the analysis from audio recordings: intensive qualitative investigations, involving transcriptions of interviews, are usually inappropriate for the service-related project, as they tend to be very time-consuming. The sample size depends on the method of data collection and analysis: e.g. studies with in-depth interviews will have a smaller sample size that those with more superficial data. The suggested sample size is 5 to 15.

Data analysis and presentation

Statistical analyses should be appropriate to the research questions and sample size of the study. Most service-related projects typically use descriptive statistics, or simple tests of association such as t-tests, chi-squares and correlations; complex statistical analyses, e.g. multiple regression, are rarely necessary. It is normally best to present data in tables, as is done in psychology journals; avoid bar charts and pie charts as they are imprecise and often hard to read. Tables should be formatted in standard APA style (e.g. no vertical rulings, minimal horizontal ones).

For qualitative data, a simple thematic analysis will usually suffice. Service-related questions tend not to require more specialised (and more time-consuming) analytic approaches. Two recommended references are Dancey and Reidy (2014) and Haslam and McGarty (2014).

Structure of the report

The report should be written up using the standard research report format: structured Abstract (with headings of Aims, Method, Results, Conclusion), Introduction, Method, Results and Discussion. For guidance on content, see the section above on "what the markers will be looking for". The name of the service should be obscured, e.g. "a forensic psychology service in North London."

Supervision

The project will normally be conducted in close liaison with the trainee's clinical placement supervisor, and it is a good idea to plan it early in the placement and to include it in the trainee's placement contract. Its progress can then be evaluated at the mid-placement review. It is essential that the trainee discusses the suitability of the topic and the proposed research methods with their course tutor before they start the project. In addition, it is advisable that students consult their course tutor again as they plan the write up of their report. If there are specific concerns or questions which arise at any stage of the SRP that cannot be answered by the course tutor, the trainee may then choose to contact either the SRP coordinator or the statistics demonstrator for additional advice.

It is good practice that any emails between course staff and trainees regarding the SRP should include the placement supervisor involved with the project, to ensure transparency and collaboration.

Ethical issues

Ethical approval is not normally needed for the service-related project (as it is considered to be audit or service evaluation), but if in doubt, discuss the issue with your clinical supervisor, and consult the useful HRA defining research table, which sets out the distinction between research, clinical audit and service evaluation. Note that NHS ethical approval is not needed for research with NHS staff.

If NHS ethical permission is needed, the only way that the project can be done is if the supervisor has already obtained ethical and R&D approval (NHS ethics procedures are far too burdensome and time consuming to be completed within the timescale for the service-related project). All projects must conform to the BPS ethical principles and code of conduct and BPS Code of Human Research Ethics.

Joint work

The trainee may report on work which they have undertaken jointly with their supervisor, although the write-up must be their own. If two trainees are on the same placement, it may be possible to conduct a project using the same data set. In this case, different aspects of the data set must be analysed by each trainee, and the contribution of each trainee must be clearly identified in both reports. The cover page of the report should say "Project jointly conducted with [trainee code number]."

If the trainee is in any doubt about whether a report will meet these criteria, they should consult their course tutor.

Additional material

There are no specific requirements, but additional material may be presented in an appendix. Copies of interview schedules or of questionnaires that are not well known should be included.

Length
The report should be up to 4000 words (including tables, figures and quotations from qualitative transcripts, but excluding references and appendices).

References

Dancey, C.P., & Reidy, J. (2014). *Statistics without maths for psychology* (6th ed.). Pearson Education.

Haslam, S.A., & McGarty C. (2014). *Research methods and statistics in psychology* (2nd ed.). Sage.

https://www.hqip.org.uk/wp-content/uploads/2018/02/guide-to-quality-improvement-methods.pdf

SECTION 19: THE MAJOR RESEARCH PROJECT

You will be working on your major research project over all three years of the course, and it will obviously require a substantial commitment of time, effort and emotional energy. These guidelines are intended to describe the process of doing the project, to outline the timetable, describe the main tasks and give you the information needed for submitting the completed thesis.

We hope that doing your major research project will be a stimulating and rewarding experience. It gives you the opportunity to explore your chosen topic in depth, and possibly will convey a sense of the excitement that comes with learning something new. Also, since research competence is important for the work that clinical psychologists do, the project will help you acquire professional skills of lasting value.

Criteria

The research thesis should be an original piece of empirical work relevant to clinical psychology, which demonstrates your ability to apply scientific principles and undertake rigorous investigation. The course supports a pluralistic approach to research. You may choose from a range of approaches and paradigms: what is important is that the research methods be appropriate to the questions being investigated.

The thesis should be of publishable quality. The course regulations state that it should make a distinct contribution to the knowledge of the subject and afford evidence of originality. The work done for the thesis must not have been submitted in fulfilment of the requirements of any other degree.

If you are working in a team, or analysing previously collected data, the boundary of what is your personal contribution can become hard to define, but the central criterion is that you should be making a substantial independent contribution to the study.

Past theses completed from 2011 are available via UCL's e-thesis repository in UCL Discovery.

Project support

In order to guide you through the process of carrying out your major research project, several sessions have been organised within the project support subunit. These take place across the three years of the course, corresponding to various milestones in completing the project. They start with the project orientation session and project clinics in the first year, which are aimed at helping you to find a suitable topic. Details are given in the Research Project Support section of Moodle.

Topic and setting

We encourage trainees to find projects within existing research groups led by course staff or staff in the wider Division of Psychology and Language Sciences or other local institutions. Potential supervisors may have a specific project to offer or will be able to help you develop one within their area of expertise. Given the limited amount of time available for the major research project, it is often difficult to carry out research on an independent topic of your choice.

All projects must have an internal supervisor who is a research-active member of the DClinPsy course team, so it is important that you discuss your ideas early on with any potential internal supervisors to make sure that they would be willing and able to supervise it. Course staff members’ research interests are given on their web pages.

Projects will normally be carried out within the London Region. Other than that, there is no restriction on the setting: it can be one of your placement settings if you prefer, though this is not necessary. If a research supervisor indicates that you need to be on placement with them in order to undertake the project, you must discuss this with a member of the clinical tutor team at the first opportunity. This is because placement planning is usually determined by clinical training need (so the “research” placement would need to fit into your overall training plan). In addition, other trainees (from this and other courses) may have a greater claim on the placement. On the whole, the tutor team will try to reconcile any problems, but can do this more effectively if the link between research and clinical placements is signalled at an early stage.

Recommended timetable

Although different projects vary in their demands, there is usually a common sequence of events that you need to consider in order to plan your time. The most frequent causes of problems are a slow initial start and unexpected delays later on, often out of your control (typically research governance procedures and recruitment of participants). Because of this, we recommend that you keep closely to the following timetable.

First Year

Term 2	Decide on the topic, start reading the background literature, and formulate preliminary research questions. Approach potential internal and external supervisors.
Term 3	Statement of intent due (date to be notified). Prepare the research proposal. Discuss the project in the setting in which you will carry it out (submission date to be notified)

Second Year

November to February	Modify the proposal and finalise the research plan as necessary. Complete the data protection and departmental risk assessment forms. Submit ethics application and project registration.
February to September	Begin recruitment of participants as soon as the protocol is finalised and research governance approvals are obtained. Begin data collection. Write the first draft of the literature review.

Third Year

Term 1	Submit literature review to internal supervisor and make consequent revisions. Complete data collection.
Term 2	Analyze the data. Write a first draft of the empirical paper and draft the critical appraisal. Title and abstract due (for allocation of examiners: date to be notified).
April to May	Revise the empirical paper and the critical appraisal. Give the final draft of the whole thesis to your supervisors for comment.
June	Submit thesis (date to be notified).
September	Viva (dates to be announced).

Supervisors

All projects require an internal supervisor, who must be a member of the DClinPsy course staff (in order to be familiar with the requirements for the thesis). Many projects also have an external supervisor, usually an NHS clinical psychologist working in the setting where the project is being conducted.

Role of the supervisors

The role of the supervisors is to provide specialised academic research expertise, e.g. on the study's theoretical and empirical background, research methods, data analysis and writing up the thesis, and generally to ensure that the research meets the appropriate standards for the Doctorate. The supervisory team typically also advises on the practical feasibility of the study, assist with obtaining a sample, and provide clinical supervision, where relevant.

Projects typically have two supervisors and the role each supervisor takes will vary from project to project, but you can expect one or other of your supervisors to suggest readings, help you plan and design your study, advise you on analysing the data and interpreting the findings and read at least one draft of the thesis (although work must be submitted in sufficient time – please do not ask your supervisor(s) to read a lot of material just before the due date!). It is advisable to meet with your supervisor(s) about every 3-4 weeks in the initial stages to set up the project; meetings will usually become less frequent as the project progresses (twice a term is the usual minimum). We do not have a formal research contract on this course, as we hesitate to introduce too much formality and regulation into what should be a flexible and mutually rewarding supervisory relationship. However, at the start of the project, the supervisors and the trainee should agree what each party’s main roles and responsibilities will be and you will be asked to confirm that this has been discussed and agreed when you hand in your project proposal. We will ask you to feedback on supervision during the course, and the Research Directors would like you to get in touch if you have concerns about your supervision.

In addition to advice from your supervisors and the research staff, the course also provides specialist statistics advice, via a statistics demonstrator who has bookable time slots.

An external supervisor is one external to the course even if they are based at UCL. Internal supervisors are members of the course staff team. All projects that have an external supervisor must also have an internal one. The course guidelines for internal supervisors and for external supervisors describe their respective supervisory roles. These are written for supervisors, but trainees might find them useful to consult.

Finding a supervisor

The project orientation session and the project clinics will help you in finding supervision for your potential project. We typically release a ‘project catalogue’ with a list of projects being offered to trainees each year by supervisors from within the course, within the wider UCL staff, and from external organisations, including the NHS and beyond. If you have an idea for a project that is not listed in the ‘project catalogue’, you are welcome to approach staff members on an individual basis. Many academic and NHS clinical psychologists, including most UCL academic staff members, are happy to discuss supervising projects in their areas of interest, although there is no guarantee that a person approached will be able to supervise.

External supervisors may be active researchers and experts in their field. They will usually be a clinical psychologist, but could also be from another relevant discipline, such as psychiatry or sociology. There are no restrictions on institutional affiliation or location, though supervisors will normally be found within the Region.

The Research Directors are responsible for ensuring that every trainee has appropriate supervision in place and for monitoring the supervision loads of course staff. All projects being offered by an external supervisor should also have a supervisor internal to the course. Should trainees experience any difficulties in finding an internal supervisor for a project that is being offered by an external supervisor, the Research Director will help to resolve these.

Keeping supervisors informed

In the early stages, when you are exploring potential projects, you may talk to several potential supervisors – up to three in the first instance. In the past, we have had some complaints from supervisors saying that they have been treated casually by trainees, who have either seemed underprepared for meeting to discuss the project, or who have not been good about communicating their intentions after an initial meeting. Please only approach supervisors if you have done some background reading first, so that you know what the supervisor's interests are and what the main literature is in the topic of interest. Also, it is vital to keep them in touch with your plans – especially if you decide to do your project with someone else.

Once the project is under way, you are responsible for keeping your supervisor(s) informed about its progress. In particular, if you are thinking of making any changes to the research protocol, you must first discuss this with your supervisors (and permission from the Ethics Committee may also be needed). This is especially important when ethical approval for the project has been given in your supervisor's name.

Statement of intent

In term 3 of the first year, you will be asked to submit a "Statement of intent." This is a one-page form that states the intended topic of your research, with the potential supervisor(s) and setting(s). The research director will review them, but will contact you only if something seems problematical.

Proposal

A proposal of approximately 2500 words is in term 3 of the first year (date to be announced). The proposal form is very structured to ensure you cover everything needed to assess the project, including (1) the background to your topic, (2) your research questions or hypotheses, (3) the proposed research methods, (4) the institutional arrangements, e.g. setting, NHS research supervisor and ethics committee, and financial implications (see the following paragraph on expenses). The proposal will be reviewed by one of the academic staff who will give you written feedback on it. For further details, see the course document on preparing the proposal.

Expenses

You will need to consider the costs of your project when you are putting together your proposal. As the course has limited funds, you may need to look into various sources of funding. If you plan ahead, you can apply to grant-giving bodies for support (although there is much competition for grants). You may also be able to obtain funds from the NHS Trust in which you are doing your research. See the course document on funding for the major research project for more details.

If you are applying for DClinPsy research funds, the research committee needs a written application in term 2 of year 2, in advance of the planned expenditure, outlining how much you are requesting and why. Normally, the amount available from the course is up to £250 per person. However, in some special cases funding up to a maximum of £400 will be granted if a strong case can be made that such additional money is essential for a project to be viable. Note that projects costing more than £400 cannot be funded by the course, so you must ensure that alternative funding is available if your budget is likely to be over that amount.

If you will be paying research participants, you need to obtain in advance a Departmental "participant payment form", which each participant will need to sign.

Research governance and ethics

The study must conform to the BPS Code of Ethics and Conduct, the BPS Code of Human Research Ethics and the HRA's UK Policy Framework for Health and Social Care Research. All of the research governance procedures that you need to complete are outlined in the research governance checklist and its associated FAQ list.

As discussed in the research methods lectures, clinical psychology research almost always requires ethical approval. When the research proposal has been approved, apply for NHS or UCL ethics approval (see the research governance checklist for further information). It is important to do this as soon as possible, as there is a lot of paperwork, and several past projects have been seriously delayed by the process of gaining ethical approval. The appendix to your thesis will need to include a copy of your official letter of approval from the Ethics Committee, as well as copies of the participant information sheet and consent form. There is a specialist member of the course team to assist with NHS research governance issues.

Health and safety issues

Personal safety issues are particularly important in clinical research, especially if you are planning to make home visits or to work with a potentially dangerous client group. All trainees must, together with their project supervisor, complete a Risk Assessment Form. It is your responsibility to familiarise yourself with the Departmental health and safety policies and to follow the guidelines in practice.

Discovering evidence of abuse or danger

It is possible that while seeing participants during your study, you become aware of an instance of abuse or potential danger, either to the participant or to others. Examples include child maltreatment, the abuse of older adults or of people in residential settings, and participants with active homicidal or suicidal intentions. In this situation, you must consult immediately with your research supervisor. You have a duty of care that obliges you to break confidentiality if not to do so would result in harm, or further harm, to the participant or to others (see the BPS code of ethics and conduct).

Monitoring research progress

The research director is responsible for having an overview of the progress of all trainees' projects and for giving general advice (although your internal supervisor should be the first port of call). You will be asked to complete regular progress reports in the Second and Third Years, in order for the research director to monitor how things are going. Should any serious problems arise with the project at any point, you should let the research director know and they will try to help sort these out.

If you experience difficulties working with your supervisor, and you do not feel able to resolve these through discussion with them, please get in touch with the Research Director and/or your course tutor. Another means of seeking help with any supervision difficulties is provided by the 'Supervisor Appraisal Form'. This is completed as part of the research review process, and is a chance to pass on feedback about your experience of supervision in confidence.

Research journal

We recommend that you keep a private research journal throughout the duration of the project. You can use this to note down ideas and thoughts about conceptual or methodological issues, decisions you make, observations and reflections about the data you are collecting, etc. This provides very useful material to draw upon when you come to write part 3 of the thesis, the critical appraisal. It is also essential for qualitative research, in which reflexivity and awareness of the influence of the researcher on the research process needs to be documented.

Writing up the project

The major research project forms Volume 1 of your thesis; Volume 2 contains three clinical reports and the service-related research report. Details on the format of the thesis, and guidelines for writing up and final presentation, are given in the course document on writing and presenting the thesis.

Marking and viva

All theses will be assessed by two examiners, one external and one internal. Candidates will be examined by an oral examination (viva voce) in September of the third year (the date will be finalised several months in advance). The viva gives you a chance to defend your work and to explain some of the conceptual and methodological choices you made and the conclusions you reached.

The potential outcomes of the examination are: (1) pass; (2) pass conditional on minor corrections (one month); (3) referred for stipulated revisions (three months); (4) referred for major revisions (one year); and (5) fail (see the criteria for evaluating the thesis). Most trainees are usually asked to make some corrections to their thesis, so it is better to resist the temptation to plan a holiday immediately after the viva.

What next?

If you have survived all the above, and still can bear to think about research, course staff will be happy to help you think about disseminating and publishing your project and also about how to continue doing research in your future career. We encourage all trainees to publish their studies. It is relatively little effort in comparison with the work involved in producing your thesis, and your supervisors will usually collaborate with you to produce a publishable paper. It's usually very rewarding to see your work in print.

Research study leave

From the second year of the course onwards, trainees can take up to six days of Research Study Leave from a six-month placement.

There are two broad reasons for taking research study leave:

a) Trainees only have limited time for research in each week, and this lack of continuity can make for inefficiency. Research study leave gives a period of time to focus solely on research

b) Some projects may require trainees to undertake research on specific days of the week (for example, collecting data or attending research meetings), and this may create a clash with placement days. Research study leave is a way of giving extra flexibility, should this be needed.

Some caveats

1) Trainees are not usually expected to take research leave from *every* placement

2) Trainees should ensure that if they are taking Research Study Leave they will have undertaken enough days on placement to meet the BPS/HCPC criteria, as indicated in the Training Handbook.

3) There is no automatic entitlement to this leave; there should be a good rationale for applying for it. Leave can be taken as a single block or as a series of days over a period of time, with the number of days taken reflecting need.

Examples of times a trainee might take study leave could include:

- A trainee who wishes to work on the systematic review over successive days in order that they can maintain the flow of their ideas
- A trainee whose research is predicated on attending clinical meetings which are always scheduled for a placement day, and who therefore needs to take days of research study leave over a period of time in order to attend the meetings
- A trainee who needs to attend a research ethics committee
- A trainee whose data-collection is best achieved using a block of time, or who needs to schedule data-collection around hard-to-book lab times

As should be clear from the above examples, decisions about taking research study leave as a block or as a series of days will depend on the need the leave is addressing.

4) There are only so many days in a year; in some placements there may well be a clash between meeting placement attendance requirements, taking annual leave and taking research leave. If this is so trainees will need to come to a judgment, deciding how best to apportion their time.

Procedure

a) Applications for research leave must be negotiated with the Clinical Supervisor, either early in the placement, or as soon as the need for leave becomes clear.

Clinical supervisors are entitled to balance the needs of the clinical placement against the trainee's need to undertake research. This means that trainees may have to take fewer than six days study time, or even no study time at all. On occasion it may be that Research Study Leave is requested later in the placement (for example if there have been unforeseen difficulties with recruitment and the study time is required to manage this)

b) If the clinical supervisor is agreeable to the leave being taken, trainees need to email their research supervisor, copying in the placement administrator:

a) indicating how much leave they are planning to take
b) briefly (but clearly) stating the rationale for taking the leave
c) stating that their clinical supervisor has approved the leave

SECTION 20: EXAMINATIONS

Unseen examinations are used to assess both the academic course component, and competence in research methods and statistics. Examinations are held in late May and Early June of the first and second year.

Papers 1 and 3 assess trainees' understanding and knowledge of theory and its application across clinical areas in which clinical psychologists typically practice.

Paper 2 tests candidates' knowledge of research methods and Paper 4 their knowledge of statistics.

Although the topics of the exams will be taken from the academic curriculum, learning during clinical placements will also be relevant, and through this the candidates' capacity to think as a practising clinical psychologist. Academic revision will need to be supplemented by an engagement in placement practice (the experience gained in clinical contexts during the training), engagement in discussion and debate during the academic programme, broad reading in clinical psychology and related areas and extended periods of reflection on clinical experience.

OUTLINE OF PAPERS

All four papers described below are 'open-book' examinations, meaning that candidates can refer to lecture notes, textbooks and other information sources. Papers 1, 2 and 3 are delivered remotely via Central Assessments team. Paper 4 is hosted on the Moodle platform.

Year 1
There will be two examination papers.

Paper 1: Theory and application of clinical psychology methods (4 hours)
The paper requires candidates to write answers on four out of 12 topics, representing the main topics and clinical approaches taught during year 1 (up to late May). The overall word limit is 3,000 words, and each of the four answers should not exceed 750 words.

The paper is split into four sections, covering psychometrics, neuropsychology and topics covered in the assessment and formulation unit (section A), psychodynamic theory and its application (section B), behaviour therapy and CBT (section C), and other modules including Key Presenting Difficulties, Professional Issues and Cultural Competence (section D). Candidates must answer one question from each of these four sections. Topics from the Central Themes (CT) unit are only covered in the exam in so far as they may present theory that is then picked up in other more substantive lectures but there is no need to revise CT lectures separately. Systemic theory and its application is covered in Paper 3 in Year 2.

Paper 2: Research Methods in Clinical Psychology (3 hours)
This paper examines the teaching in the Research Methods sub-unit. Candidates are required to read a peer-reviewed paper and then answer questions on it. In effect, this asks candidates to apply the teaching on the Research Methods sub-unit to critiquing a paper. The overall word limit is 3,000 words.

Year 2
There will be two examination papers.

Paper 3: Theory and application of clinical psychology methods (advanced level) **(**4 hours)
The paper requires candidates to write answers on four out of 12 topics, under four sections representing the main topics and clinical approaches taught after the first-year exams and during year 2 (up to late May). The overall word limit is 3,000 words, and each of the four answers should not exceed 750 words.

The paper is split into four sections, covering children and young people (section A), older adults and intellectual disability (section B), systemic therapy (section C), and other topics covered during year 2 under the Clinical Health and Key Presenting Difficulties units (section D). Candidates must answer one question from each of these four sections.

Paper 4: Statistics (4 hours)
This exam covers all aspects of teaching in the Statistics Unit. Candidates will be presented with a series of multiple-choice questions that pertain to statistical concepts and require the interpretation of charts and graphs. Additionally, they will receive a data set accompanied by a description of its context. Candidates will apply the statistical and computational knowledge acquired from the course to answer a number of focused questions about the data set and answering specific research questions as part of the examination.

As with all examinations outlined in this section of the handbook, candidates are permitted to refer to their study materials during the assessment. The exam can be completed at a time that suits the student's schedule. Each candidate is granted up to two attempts to pass the examination before the stipulated deadline. Should a candidate not succeed, they have the opportunity to retake the assessment during the summer assessment period, with an additional two attempts allowed.

The assessment will be hosted on the Moodle platform. Although students can choose when to start the assessment, each attempt is constrained by the two-hour time limit. Once begun, the assessment must be completed within the designated time frame in order to qualify for a pass. Feedback will not be provided after the first attempt. However, if a student is unsuccessful on their second attempt, feedback will be given to help them understand their areas for improvement

Timing of exams

Year 1, Paper 1	May of Year 1 (for date see timetable)
Year 1, Paper 2	May of Year 1 (for date see timetable)
Year 2, Paper 3	May of Year 2 (for date see timetable)
Year 2, Paper 4	End of statistics teaching until May of Year 2 (for date see timetable)

Marking
Marking procedures are outlined in Section 24 of the handbook.

Re-sits
For Papers 1, 2 and 3 the re-sits will be scheduled by UCL Examinations under the Late Summer Assessments programme. This is usually within a three-week period from the third week of August.

For the Statistics Examination this can be taken between July and September and will be scheduled by the Course.

Artificial Intelligence (AI)
UCL assessments are categorised according to how AI tools may be used. Like all assessments for the DClinPsy programme, examinations fall under **Category 1: AI tools cannot be used**. The examinations are designed to test competencies in critical thinking, knowledge application and clinical practice, which are essential and fundamental to working as a Clinical Psychologist. Trainees should therefore be aware that use of AI tools in examinations would constitute **academic misconduct**, and further information is provided in Section 23 of the Handbook (Plagiarism and Artificial Intelligence) and on the UCL website here and here.

Examination Arrangements for Students with Disabilities or medical conditions
UCL makes provision for students who have a disability or medical condition that would make it difficult to undertake an examination under standard examination conditions.

Initially you may wish to discuss your needs with your course tutor, who will be aware of the procedure.

You should submit a request for alternative arrangements well in advance of the exam if you wish to be considered, as it is UCL Examinations Section (not the Course) that grants permission for any special arrangements. Applications should be submitted as early in the academic year as possible, and **not later than six weeks before the start of your first examination**.

Specific information about arrangements for students with disabilities can be found at: www.ucl.ac.uk/disability/special-examination-arrangements

Instructions on how to apply can be found at: https://www.ucl.ac.uk/students/support-and-wellbeing/disability-support/reasonable-adjustments-your-assessments

SECTION 21: CLINICAL REPORT GUIDELINES

PART 1: GENERAL INFORMATION ABOUT CLINICAL REPORTS

AIMS, FORMATS AND BREADTH OF CONTENT

Aims

The work clinical psychologists undertake is underpinned by their ability to apply models and theories, used in a reflective way. Most clinical work can be seen as a process – assessment leads to hypotheses about how best to intervene, and monitoring the way the intervention unfolds provides feedback about how well these hypotheses fit the clinical picture. A sense of openness to this feedback and a capacity to reflect on one’s own practice (often through supervision) is central. All of this represents clinical competence, and clinical reports are a chance for you to demonstrate this and your development as a clinician. As such, the course uses them as one of the indicators of your capacity to function as a Chartered Clinical Psychologist.

Overall, they give us a chance to look at:
a) your developing clinical competence across a range of different types of work and setting, in the context of a range of theoretical perspectives
b) your ability to integrate academic and theoretical ideas with your clinical experience
c) your ability to reflect on the way in which clinical, professional and ethical issues interact and impact on your work
d) your ability to meet the expectations of professional behaviour, including the standards of conduct, performance and ethics issued by the HCPC and the BPS.

Formats

You need to complete a total of four clinical reports (including one service-related research report, which is described in Section 18 of the Training Handbook).

There are two compulsory formats (plus the service-related research report):
1) The first clinical report (submitted during the second term of the first year) must be a report of an assessment.
2) A report based on a transcript (taken from an audio recording), using the actual clinical material to reflect on therapy process. This is usually submitted as the second report.

For the remaining clinical report you can choose from the formats in the table below.

Possible formats for clinical report	a single-case study
	an “advanced” assessment report
	a theory-oriented report
	a report of a completed clinical intervention
	a report of an impasse in a psychological intervention
	a report of inter-professional and/or inter-agency working
	a report of a consultation with experts by experience/carers
	a report of a piece of leadership work

The criteria for these clinical reports are described in more detail in Part 2.

SCHEDULE OF SUBMISSION

The table shows the usual sequence of submission. If there are significant barriers to collecting the appropriate materials for a specific format (for example, where it has proved impossible to record a session and there is no material for a transcript-based report) trainees should consult with their Course Tutors to discuss arranging a variation in the submission schedule.

		Type of report
Year 1	Two reports submitted	Clinical report: compulsory format - report of an assessment
		Clinical report: compulsory format - transcript-based report
Year 2	One report submitted	Service-Related Research report
Year 3	One report submitted	Clinical report (choice of format) or in exceptional cases transcript-based report or Service-Related Research report if not yet submitted

Submission dates can be found on the course website. See Section 25 for further details on handing in work.

Breadth of content

By the end of the Course you will have a "portfolio" of four reports (including the Service-Related Research report). The aim is for this to cover a reasonable range of clients, contexts and interventions – the idea is to demonstrate some progression in your thinking and the development of a repertoire of skills applied in a variety of settings. None of this would be very apparent if, for example, all your clinical reports described treating a person with an anxiety disorder using CBT.

As far as possible you should aim for a portfolio which covers as fairly broad a range of clients, contexts and types of intervention. There may be limits to this, especially because the first two reports have to be based on the work that is available to you in the first 12 months of the Course. Nonetheless, you should aim for as great a diversity of reports as your placement experience permits. Bear in mind that the Service-Related Research report will contribute to demonstrating the breath of content and setting.

It is always a good idea to discuss the appropriateness of a piece of clinical work with your Course Tutor before you start writing the report.

Defining "breadth" is best done in relation to the BPS accreditation criteria (a schematic diagram showing these can be found at the end of this document). It's worth remembering that one piece of clinical work can cover quite a few of these factors at once, though as above, your choices may sometimes be limited. If in any doubt, talk this over with your Course Tutor.

a) <u>A range of clinical work drawn from across the lifespan:</u>

This is defined as at least:

- one piece of clinical work with a child or young person (under 18)
- one piece of clinical work with an adult of working age or person in later adulthood (aged 65+)

These age-bands indicate the spread of ages to aim for, and are not intended to be interpreted rigidly. The important point is that you should try to choose pieces of clinical work that can show your competence in working with individuals and systems across the life-span.

b) A range of severity and chronicity of presentation:

The meaning of terms such as severity and chronicity may vary across different client contexts, but ideally the portfolio of reports should describe individuals with a range of presenting problems – from acute onset through to serious and enduring presentations.

c) A range of psychological approaches:

You should be able to demonstrate competence in more than one model of formal psychotherapy. Bear in mind that in this context “model” is a reference to broad approaches - cognitive-behavioural, psychodynamic, systemic, humanistic, or integrationist. On this basis, breadth would not be represented by variations on cognitive approaches, or by Kleinian as contrasted to Freudian modes of psychodynamic therapy.

d) A range of settings:

As far as possible, the portfolio of reports should cover work carried out in different contexts – in the BPS criteria these are defined:
i) in relation to different levels of the healthcare system (primary care, secondary or tertiary/specialist), and
ii) in relation to the intensity of treatment and the likely dependency level of the client - whether patients are treated as outpatients, in more intensive settings (for example a day-unit), or in residential settings (such as an in-patient setting, residential homes or a therapeutic community).

Obviously the number of reports limits the number of settings you can cover, but you should aim for a range, and try to ensure that at least one report describes work undertaken in the context of inter-professional working (e.g. where the work involved direct or indirect work with another professional or with members of a multi-disciplinary team). As noted, the Service-Related Research report will contribute to demonstrating breath in your “portfolio”.

In summary, the “portfolio” of reports should ideally include:

clients drawn from across the lifespan
variation in severity and chronicity of presentation
variation in psychological approaches
variation in settings
at least one report demonstrating inter-professional working

PRESENTATION OF REPORTS

Basic formatting

Reports should be:

- Typed
- Double-spaced
- Stapled
- Each page must be numbered

All reports should be prefaced by a cover sheet that includes the following information:

- Title of report
- Type of clinical report (e.g. “assessment report”, “theory-oriented reported” (etc))
- Number of report and date of submission (e.g. Clinical Report 1, January 2012)
- Your Clinical Report code (issued to you by DClinPsy professional services staff)
- The word count (see below)
- A formal statement regarding confidentiality, as follows:
  “all names used in the report have been changed in order to preserve confidentiality”
- A statement indicating that client consent was sought/obtained for the report, and (if consent was not sought), a clear explanation of the reasons for this

All citations and references should be in APA format.

Supervisor “signoff”

Your supervisor needs to submit a form indicating that they have seen the report and that it is a fair representation of your work (the form is available in the ‘useful forms’ section on the DClinPsy website).

You should not ask your supervisor for feedback on the report, and they should not offer it. Their role is solely to confirm that the report is an accurate representation of the work undertaken, not to comment on your (or indeed their) understanding of the work.

Length of reports (word count)

The maximum word count for clinical reports is 3000 words[1]. This is an absolute limit, which cannot be exceeded. The word count ***excludes***:

- The front (cover) page
- References
- Appendices

The only exception to this word limit is where a transcript from a taped session is included; guidance on this point is given in the description of the “transcript based therapy process report”.

Quality of writing, grammar and spelling

Clinical reports are submitted as formal assessments. As doctoral level reports they should be clear, with few spelling or grammatical errors, or errors introduced as a result of word-processing. You are strongly advised to use the spell and grammar-checking facilities offered by your computer, and to read through your reports *before* they are submitted.

Up to a point, content is the main focus. However, you may well be required to revise reports that contain a large number of grammatical or spelling errors. If a trainee appears to have serious difficulties with their writing, the course expects them to acknowledge this and to work with their tutor on a plan to identify the actions needed to remedy this. This could include attendance at one

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[1] The maximum word count for the Service-Related Report is 4,000 words.

of the writing courses offered by the UCL Centre for the Advancement of Teaching and Learning (CALT) (www.ucl.ac.uk/calt/).

Preserving copies of clinical reports

The reports will be marked internally as you submit them. On the basis of feedback some reports may need to be revised. It is your responsibility to keep copies of your reports in such a way that they can be called upon if needed. For this reason, it is critical that you retain a secure electronic copy of the final version of each report.

CHOOSING A PIECE OF CLINICAL WORK

Understandably, trainees often imagine that the Course is looking for reports of “successful” pieces of clinical work. In fact we are looking for the ability to make links between theory and practice, to reflect on the work and to show appreciation of any issues raised by the clinical material. Whether the clinical work had a “good” outcome is much less relevant than your ability to demonstrate a thoughtful and sensitive approach to practice.

You do not need to restrict yourself to work that has been completed; unfinished work can be just as interesting and useful. Clearly there is a balance here: it may not be sensible to submit a report based on a very limited amount of clinical contact.

Clinical reports do not need to be based on “complex” pieces of work, or ones that are especially “interesting”. Routine clinical work is fine, and in reality pretty much any piece of clinical work could be written-up. Sometimes trainees avoid writing up straightforward work because they fear that it is not “interesting” enough; bear in mind that even straightforward pieces of clinical work can be difficult to write up, and complex work very challenging!

Reporting joint work

You may submit a report on work that you have undertaken jointly, but the report should always make clear which aspects of the work were your own responsibility. This includes work which you have carried out with your supervisor, although the write-up should be your own. If you are on placement with another trainee, you could submit a report on work you have done together (e.g. running a group, or delivering training to a team, etc.), but this is only appropriate if each report focuses on a separate, defined piece of the work and cross-references the existence of other report.

SUPPORT FOR WRITING THE REPORT

Involving your course tutor

You are strongly encouraged to discuss your ideas about the clinical report with your course tutor before you start writing. Tutors can help you think about which of your current pieces of clinical work seem most appropriate for a report, and which format is best suited to the write-up.

Tutors cannot look at a draft of the report though because it is an assessed piece of work. However, they can discuss the proposed structure of the report; this is often extremely helpful in helping trainees to think both about focus and content.

Role of your clinical supervisor

It is a good idea to discuss your plans for a clinical report with your clinical supervisor, since they will be familiar with your ongoing work. However, although your supervisor's opinion is useful, the clinical report is *your* work. This means that it should reflect your ideas, and may not (and does not need to) include all the areas discussed with your supervisor.

As described on page 4, you need to show your supervisor the final version of your report, and they need to sign and return to college a standard letter confirming that you undertook the clinical work you describe. Bear in mind that the supervisor is not being asked to judge the quality of the work, only to confirm that it reflects the work you carried out.

MAINTAINING CONFIDENTIALITY

Although markers will always pay due attention to confidentiality, it is absolutely essential that anyone reading the clinical report should be unable to work out the identity of your client. Achieving this requires great care, since it is surprisingly easy to include details that could (however inadvertently) breach confidentiality. Some tips may be helpful:

1) Never use real names – these must be changed, and a statement indicating that this has been done should be included on the cover sheet.

Rather than inventing names, it makes more sense to refer to “Mr A”, or “Ms B” because this makes it clear that these are not real names. It also removes any risk of reverting to the client’s real name if you invent a pseudonym. However, if there are a lot of people in the report, invented names become a necessity (there is a limit to how many Mr S’s, E’s and T’s the reader can keep track of), but make sure you proof read carefully and check that you’ve maintained the same pseudonym throughout.

2) Make sure that there is no information which could inadvertently identify the location of the service. For example, if the service has a particular name (“The Retreat”, “The Pathways Project”), this will identify the location where the client is being treated. Less obviously, even giving broad geographical information can narrow down the location of the service. For example, reference to ‘a medium-secure forensic service in East London’ identifies this as the John Howard Centre (since there is only one forensic service in this area), and so breaches confidentiality. In this case ‘a forensic service’ is all the information that is needed.

3) If you include letters or reports in the appendix, take great care to remove all addresses, Trust logos and references to your name, the name of the patient or anyone involved in their care, and any professional involved in the work. You need to pay careful attention to detail in relation to this, because it can be surprisingly easy to overlook names in the body of a document.

4) You should include only necessary items of demographic and clinical information. You can usually do this quite easily without distorting relevant facts - two examples show how:
1) 'The client is a professional in her early forties' *is better than:*
'The client is aged 43 and works as a solicitor in a small law firm'

2) 'The client lives in a large and run-down housing estate' *is better than:*
'The client lives in a tower block on a deprived housing estate in Dalston'.

5) Providing details of the history (for example size of family, ages and sex of family members, occupation, timing of problem onset, specific details of the presenting problem) may provide identifying information to somebody reading the report. This risk increases if the report includes a lot of unusual details which, taken together, could reveal someone's identity.

Bear in mind that the more details you give, the more confidentiality is at risk. Equally, withholding information to preserve confidentiality can deprive the reader of crucial clinical information. There is a balance to be struck, and it is worth giving careful thought to this issue. However, if describing the clinical work fully would inevitably reveal the client's identity; it will be unsuitable for writing up as a report.

GAINING INFORMED CONSENT FROM CLIENTS FOR CLINICAL REPORTS AND FOR RECORDINGS

Consent is the voluntary and continuing permission of the client to receive a particular intervention. Trainees are following an educational programme, and this means that there are some additional factors that clients need to be aware of when granting consent - in particular the fact that their clinical material will be discussed regularly with supervisors, and may also be discussed with programme staff, or written-up in the form of a clinical presentation or report.

Before describing how consent for clinical reports is obtained, it is helpful to revisit some basic issues:

Who can give consent

All clients over 16 years are presumed to be able to give consent for themselves, unless it can be demonstrated that they lack capacity to do this.

Clients who lack capacity to give informed consent to a clinical report

Some adults may lack the capacity to give or withhold consent to a clinical report – for example, they may have impaired cognitive capacity due to brain injury, severe learning disabilities or dementia, or severe mental health problems.

Judging capacity is not always straightforward and before concluding that a client lacks capacity to consent to a particular decision, every effort should be made to try to communicate with them and provide information in a manner that supports their ability to make a decision on their own. If someone has capacity to give consent but is physically unable to sign a consent form then an independent witness can be asked to confirm that the client has conclusively given their consent.

If it is not possible to gain consent from the individual concerned then a careful decision should be reached in discussion with your supervisor as to whether focusing a clinical report on the person may in any way contravene their best interests or pose a risk of adversely affecting them or those around them. Where the work involves others, e.g. family members or a staff member and they also feature in the report, this discussion will usually involve them.

Children under 16 years old

When working with children under the age of 16 years, parental consent must be obtained. If a child under the age of 16 years has sufficient understanding they may sign a consent form for themselves. Wherever possible it is good practice to involve the child – it is best for work to take place with the consent of both child and parent/carer.

Gaining consent from families or groups

This is achieved using the same principles as for individuals, adapted to the service context and the age and capacity of the individuals concerned.

PROCEDURE FOR GAINING CONSENT TO THE USE OF CLINICAL MATERIAL IN A CLINICAL REPORT

The default position is that clients should give consent to the use of material for clinical reports (bearing in mind that the word ‘client’ can refer both to a single or to multiple individuals – essentially consent needs to be sought from those with whom the work is being conducted). The report could be seen as equivalent to a clinical record: as such clients are entitled to know that such a record has been created, and be in a position to consent to the use to which it will be put.

Consent procedure

It is usually best to obtain consent for clinical reports at the start of an intervention, and integrate this request with the process of obtaining consent for the intervention itself. Consent does not need to be revisited at a later stage of the intervention (when decisions have been made about which report to write) unless there is an explicit reason to think that the client may have reconsidered consent - most obviously when clients raises the issue explicitly. However, oblique (and especially repeated) references that could be interpreted as an unexpressed concern or worry about the report should not be ignored. In such circumstances it would usually be best to have a discussion with the supervisor and consider how best to proceed.

Trainees should ask clients to complete the consent form, downloadable from the ‘Useful Forms’ section of the website (and including an ‘easy-read’ version for clients with a learning disability or cognitive impairment), and be prepared to answer any questions the client has about its content.

Submitting reports when client consent is not obtained

The purpose of writing a clinical report is educational, and it differs from a clinical record in many respects – for example, it is anonymised, and some clinical details maybe withheld in order to preserve confidentiality. Its focus is often on the rationale for intervening as much as it is on the intervention itself, and it contains reflections on the clinical work that include the trainee’s personal reactions to the client. This educational purpose means that there may be some types of clinical work that it would be appropriate to submit even where client consent is difficult to obtain – for example, with clients who have been very hard to engage (perhaps because they have paranoid thoughts, or the intervention is characterised by marked interpersonal strains). As such there may be occasions where the educational purpose of a clinical report justifies its preparation in the absence of client consent. Because this is an exception to the usual requirement the following governance procedure needs to be followed.

If you are considering submitting a clinical report where consent has not been obtained you should consult firstly with your supervisor and with your Course Tutor. You will need to explain (usually verbally) the reasons why consent will not be obtained for the report – usually where there are clinical reasons for the difficulty in obtaining consent and where there is no evidence that writing the report will impact adversely on the client’s welfare or continuing treatment. This procedure is akin to presenting a research proposal to an ethics committee, and as with an ethics committee the intention is to ensure that any decisions made are in line with the BPS Code of Ethics and Conduct. In particular it needs to be established that there will be no harm to the client as a consequence of the report being written.

When a report is submitted without a client’s consent a brief statement needs to be included in the Appendix outlining the rationale for proceeding in the absence of consent, identifying any ethical concerns and explicitly confirming that the procedure outlined above has been followed.

It is important to hold in mind that if a client has explicitly refused consent for a report then their material cannot be written up.

GAINING CONSENT FOR RECORDING SESSIONS

Session recording should never take place without a client's consent. In considering whether to agree to this, clients will want to know why the recording is being made, the uses to which it is being put, the precautions taken to ensure that it is kept secure, and the arrangements for its 'disposal'. These issues are outlined in the consent form, and trainees need to be prepared to discuss them with clients and to answer any questions.

Ensuring the security of session recordings using encryption

It is Course policy and a legal requirement to encrypt personal data that relates to clients (or indeed to research participants or any other individuals with whom trainees work in a professional capacity). This ensures that data cannot be accessed by unauthorised third parties, a particular risk if the storage device (such as a memory stick, computer or digital recorder) is lost or stolen (the most common causes of security breaches).

Course policy is that recordings are only stored in encrypted form on an encrypted memory stick with an integrated passcode facility. It follows that unencrypted recordings should never be stored, either on a digital recorder or on an unencrypted memory stick.

Some Trusts will provide encrypted memory sticks and/or voice recorders, and in some settings recordings can only be made/transferred using these. It is important to follow Trust policy if such restrictions exist and alternative arrangements are not permitted. However, we understand that the procedure set out below conforms to NHS Information Governance standards.

Encrypting digital recordings using a standard digital recorder and an encrypted memory stick with an integrated passcode facility

Trainees must follow the procedure outlined below when using a standard digital recorder (clearly if the recorder has built-in encryption the following steps are not required).

Step 1:	Set a strong (i.e. long) passcode onto the stick (you should not use a short code or one that is easy to recall (e.g. 1,2,3,4,5,6)
Step 2:	Record the session using a digital voice recorder
Step 3:	Immediately following the session, transfer the recording to the encrypted USB stick
Step 4:	**Immediately delete the file from the recorder**
Step 5:	When replaying the recording, do so *only* from the USB stick. Never transfer the recording to a computer, as this would require it to be decrypted (this would defeat the whole exercise, as it would create an unencrypted file!)

Step 4 is absolutely critical, and should take place as soon as is practical after the recording is made – if you leave the recording on an insecure (unencrypted) device it is at risk.

Advice about purchasing a suitable encrypted USB memory stick
USB sticks with an integrated passcode and 256bit AES encryption are now reasonably priced. An 8 GB or 16 GB stick is sufficient and should cost between £20 and £30.

Advice about data storage and encryption
Helpful guidance can be found here:
https://www.ucl.ac.uk/information-security/technical-advice/encryption

Retention of recordings
Recordings are made with an educational purpose in mind, and should only be retained for as long as they fulfil that purpose. This means that they should be deleted when no longer required, and usually at the end of the placement. However, some course requirements include submission of session recordings (for example, transcript-based clinical reports or the clinical viva). This means that recordings should be retained until it is clear that they will not be requested as part of an assessment for educational purposes.

Marking criteria
These can be found in Section 25 of the Training Handbook.

Submission deadlines
Deadlines for submission will be published on the Course website at the start of each academic year. **All work must be handed in by 10 am on the date required.**

Requesting an extension
see Section 25 of the Training Handbook.

Procedure for submitting reports

Clinical reports should be submitted as Word files in the appropriate Moodle folder (e.g. 'Clinical Report 3: Original Submission').

We will only require electronic submission via Moodle; no paper copy is required.

The Clinical Report should include a front sheet, stating:
- The type of report (e.g. "Clinical Report 1: Assessment Report)
- The title of the report
- The word count
- The date
- Your Clinical Report code (e.g. T30)
- A formal statement regarding confidentiality, as follows: "all names used in the report have been changed in order to preserve confidentiality"
- A statement indicating whether or not client consent was sought/obtained for the report, and (if consent was not sought) an explanation for this in the report's Appendix, as outlined above.

To ensure that the markers can blind mark, **please make absolutely sure that your name is not included in either the file name or the saved document– instead make sure that you name the file with your Clinical Report code (e.g. T30_CR4).**

Because Moodle and Turnitin submission can be rather slow trainees should not leave submitting their work until the last minute, since this will not leave enough time to run a test submission and check for inadvertent plagiarism.

Any queries relating to Clinical Report submission should be addressed to the responsible member of the professional services team.

Using "Turnitin"

As is the practice in many institutions, the course uses Turnitin (a plagiarism-detection software) for clinical report submission. Trainees should read the student guide on using Turnitin - it contains further explanations of plagiarism, and instructions on how to use the programme: https://www.ucl.ac.uk/students/exams-and-assessments/academic-integrity/useful-resources

Naming files: When uploading your report, the filename inserted into the 'Submission Title' field is simply the type of report and your clinical report code (e.g. CR4_T30). You must not include your name because this would identify you to the markers.

Checking for plagiarism: Turnitin is being used to encourage good academic practice and referencing, not to catch trainees out. For this reason, the system has been set such that trainees can submit their clinical report, look at the Turnitin report to identify any sections where they may be at risk having inadvertently plagiarised, delete the submission and submit a revised report.

Resubmissions can be made up to the 10am deadline on the day reports are due. However, it is important to allow for the fact that Turnitin only allows one submission every 24 hours. This means that trainees will need to factor this in to any plans for checking and resubmission.

Turnitin will give each report an originality score: this identifies text matches with other documents, including (for example) any quotations. There is no target score that needs to be achieved - the critical point is to ensure that ideas and quotations are properly referenced in an appropriate academic style, not to aim for a particular unoriginality score. As such trainees should use their own judgment to decide whether higher scores are legitimate (for example, because Turnitin has picked up. a properly cited quotation). In this regard trainees will find it helpful to refer to the excellent guidance on UCL's website (https://www.ucl.ac.uk/students/exams-and-assessments/academic-integrity), which is also included as Section 23 of the Training Handbook.

Checking that the report has been submitted

If the report has been successfully submitted Turnitin will issue a receipt with the date and time of submission. If this receipt is not issued trainees should assume that the report has not been submitted (i.e. there has been some sort of malfunction). If attempts to resubmit are not successful the professional services team should be contacted so the course is aware of the difficulty.

PART 2: GUIDELINES FOR THE FORMAT OF REPORTS

General comments about the structure and content of reports

The comments below are *general* observations. The *specific* criteria for each style of report follow below.

It is important to think carefully about structure and content before you start writing. There is a discipline to writing clearly and concisely, guiding the reader to what is important, and leaving out irrelevant detail. Two fundamental questions to ask yourself are:
"What facts does the reader need to know about in order to understand the work, and what's the best order for reporting them?"
"Which issues are critical, and which issues are interesting, but not strictly relevant?" This is a question about the focus of the report - particularly important given the word limit.

Reports will vary in terms of their structure and contain multiple elements. However, all reports should always contain: 1) An introduction; 2) Cultural and contextual considerations; 3) A formulation and 4) Reflections. These elements may vary depending on the specific report structure, and markers and trainees should attend to the specific report format guidance below as well as to the marking guidance document appended to Section 25 of the Handbook for further information.

Reports should start with a *brief* introduction. This should orient the reader by a) setting out the main clinical and conceptual issues with which the report is concerned, and b) indicating the material to be covered.

Consider what aspects of the history and what relevant background information the reader needs. Try to be concise, but include enough detail so that the reader is supplied with *all* the basic facts they need at an early stage (a common fault is to embed relevant material at a later point). While succinctness is important, the reader should be able to appraise the client and their presenting difficulties in the context of their lives and relevant historical, social, cultural and religious factors.

Most reports will contain hypotheses about, or a formulation of, the presenting issues in the context of the person's life. These should fit with the history, and (as far as possible) explain how the problem developed, what is maintaining it, and (by implication) how it might change. They should be informed by psychological theory and relevant literature.

Take care to distinguish between facts that you know about, and speculation or opinion. Linked to this, be careful to identify the source of (and sometimes the evidence for) important facts. For example, a statement that the client had an "abusive childhood" could be based on a comment made by the patient, a passing reference in clinical notes or the fact that their father was jailed for abuse – each of these has a very different status and meaning. Finally if the client's view of the problem is not consonant with your own or that of fellow professionals, make sure that this is made clear (in other words, if you suspect that the client sees the "facts" differently from you, this is important to note).

As a general principle, all clinical reports should contain a formulation, meaning that a conceptualisation of the piece of work is presented, and linked with relevant psychological theory. Trainees will often need to go beyond course teaching, and undertake independent reading to develop this thinking. Reports of client-facing work such as an assessment or intervention should include a written formulation, linked with relevant psychological theory, demonstrating how the presenting problem/s have been conceptualised. Reports of consultation, leadership or other systems-level work may not contain a traditional formulation, but should include at some stage a written explanation of how the piece of work has been conceptualised, drawing on relevant psychological theory.

It is important that formulations and the report show some coherence in relation to the model you are using. For example, it would be odd to follow a comprehensive psychodynamic formulation with an account of a behavioural intervention. Equally inappropriate would be a report in which an intervention which claimed to represent one modality actually used techniques from an alternative approach, without acknowledging this.

Discussion of the intervention should try to show how the formulation and, where applicable, intervention link together in a 'dynamic' manner. This usually means selecting relevant (i.e. illustrative) clinical material, and limiting yourself to details that are strictly necessary to showing your developing understanding of the work.

Your report should be reflective in tone throughout, but in addition it must include a section that offers reflections on your work. This section must include reflections on points of learning and/or ideas for how you would (or could) do things differently.

Further reflections may include consideration of wider issues raised by the work and its impact on you. Your reflections may also draw on: learning from teaching sessions where Personal and Professional Development is a key focus, such as insights gained through reflective practice seminars or Social GRACES groups, and how these relate to the clinical work presented; reflections on outcomes; alternative ways the piece of work could be conceptualised or treated; reflection on relationships (including therapeutic process issues), or on broader implications for the model or evidence base.

CONSIDERATION OF THE CONTEXT

All reports should include an appropriately reflective and developed description of relevant cultural and contextual factors. While observing the need for brevity and confidentiality, you should ensure that you pay attention to key contextual factors, be this the social, cultural or religious context and historical factors which are essential to understanding the current presentation. You should ensure that you balance the need for a clear focus and succinctness with the need to present clients as people that live within and act out of a context and should refrain from presenting them as a “clinical case”, devoid of context.

The above relates to describing the person’s background, but crucially you should also actively consider the influence of contextual factors when assessing, formulating, and planning your intervention, or when making sense of how the person is experiencing and responding to sessions. For example, you might intend to consider the role of trauma and post-traumatic stress disorder in formulating depression. When referring to a history of trauma in the referral section, you may also want to consider the influence of the person’s religious background when developing a formulation of delusional beliefs, acknowledge the absence of social support and poverty when understanding engagement with a proposed intervention and reflect on the role of past or ongoing threat (e.g. domestic abuse; racism; bullying) when considering challenges in developing a therapeutic relationship. In reports describing consultation, leadership or systems-level work, relevant cultural and contextual considerations should be identified and linked with the approach taken.

Using diagrams to illustrate formulations – a caution

All reports should include a text-based formulation. Diagrams should only be used to illustrate material that has already been alluded to in the text (for example, to show the relationship between various elements in the presentation). They should not be used as a substitute for a full written account of the formulation.

If you do use a diagram it should be labelled as a figure, and referred to as such in the text.

Measures

You should include any methods you used to evaluate your work, and any numerical data you collected (raw data is usually included in an appendix).

It is good practice to report scores with confidence intervals (where these are available), as well as standard scores/ percentiles/ descriptors.

Wherever such data is available, there should be an indication of the clinical implications of any test results. For example, stating that a client has a BDI of 32 does not convey very much. Reference to normative data will tell you that this indicates a fairly high level of depressive symptoms. On this basis the score would be reported as:

"The client scored 32 on the BDI, which would indicate a high level of depressive symptomatology".

Another example might be:

"The client’s score of 23 on the Recognition Memory Test places them at the 10th percentile".

If you have test results from previous recorded assessments, it will be helpful to contrast these with your results, and indicate the implications both of stability and of change.

References

Where relevant, you should cite pertinent literature. Bear in mind that the purpose of references is to give academic authority to your assertions, and to guide the reader to the source of major ideas that you are discussing. This should be done judiciously. We are not expecting a long reference list, and more references do not necessarily make a report more authoritative – their relevance to your discussion should be the basis for their inclusion. All in-text citations and the reference list must be presented in line with APA guidelines.

COMPULSORY REPORT (CLINICAL REPORT 1): ASSESSMENT REPORT

Aim
The aim of this report is to describe the assessment of a psychological problem, and the results of that assessment.

Competencies to be demonstrated
The report is intended to allow you to show that you have been able to plan and carry out an assessment that addresses the question(s) presented in a referral.

What the markers are looking for
The markers will be looking for evidence that you have identified the appropriate questions that need to be addressed, and used your theoretical and practical knowledge to plan a suitable approach to attempting to answer them. (In this context the use of theory is quite specific – this is described below in the paragraph on content.)

They will want to see how you engaged the client in the assessment process, a clear rationale for the range of information gathered, and that this information is interpreted sensibly.

Examiners will expect hypotheses about the presenting issue/s, but won't expect a full formulation, especially if (as is likely) the assessment is only partly complete or the clinical work is at a very early stage. Distinguishing between a set of "hypotheses" and a "formulation" isn't easy – formulations are, after all, made up of hypotheses. In the context of the marking criteria, the distinction is made because:
a) in the assessment phase any ideas you have about the client are probably tentative (you may well be missing some important information). This means that you are more likely to hypothesise, rather than to derive a fully-formed formulation (which may well be premature).
b) formulations are internally coherent. In contrast, when attempting to make sense of ambiguous information, you may come up with a number of alternative hypotheses, some of which may even be contradictory.

If you are presenting a set of hypotheses, it is a good idea to indicate what additional information would be useful in order to clarify any areas of uncertainty, or decide between competing hypotheses.

Where you have used standardised measures, the markers will want to see that you have understood the properties of the measures and are aware of their strengths and limitations.

They will also want to see that you can reflect on and be appropriately critical of the assessment.

Type of material
Any type of clinical work would be suitable. For example,

- an assessment for a direct or an indirect psychological intervention
- an assessment aimed at clarifying the nature of a presenting difficulty
- an assessment aimed at determining whether a problem is related to psychological or neurological factors

Assessments could be based largely on an interview format, could use formal procedures, or employ a mix of the two. The format will usually depend on the nature of the referral.

You can report on joint work, but if this is the case you should have been responsible for most of the work reported. You cannot report on work you have observed.

Content

Bearing in mind the general comments above, reports will usually include consideration of the following:

- The service context in which the referral took place, and the way in which this influences and shapes decisions about the scope of the assessment and the assessment procedures.
- How the assessment procedures used can answer the questions posed by the referral.
  For example, if psychometric assessments were used, what were the reasons for choosing the specific assessment? If the assessment was for psychological therapy, how and why was the interview conducted as it was? If a client was assessed on a ward, and information gathered from specific members of the ward team, what was the rationale for choosing who to talk to?
- What cultural and contextual factors were identified, how did these influence the assessment, and how did you take account of these in your understanding and approach to the work?
- What models were drawn on in conducting the assessment. Markers will be aware that in some settings a clear model is used from the outset, while in others a more pantheoretical approach is adopted. Whatever the starting point, as clinical facts emerge, theories and models will make certain lines of questioning more or less pertinent, and this sort of structuring is worth making explicit in your report. For example, if it became clear that the major problem was one of panic, a CBT model of panic disorder would lead you to ask certain sorts of questions, and you should (broadly) indicate how the model led you to these lines of inquiry.
- What information was gathered. This will need to be structured so as to present a coherent account of the information gathered. A common challenge will be to decide which material is relevant, and which peripheral.
- Brief considerations about the presence of risk (e.g. to self, to/from others, substance misuse, etc.) and, if present, details about how risk was assessed, monitored, and/or managed.
- A written formulation, linking the presenting material with relevant psychological evidence and theory.
- Any ‘process’ issues which were pertinent – for example, difficulties in engagement, or ways in which a standard assessment procedure needed to be adapted to meet the needs of the client.
- How the information gathered clarifies the referral problem. How do you now understand the clinical problem, following the assessment and in the light of the information you collected?
- What clinical recommendations can be made on the basis of the assessment? How does your assessment help you to define what should be done next? What areas do you need to know more about?

In concluding the report it will be essential to reflect on the assessment as a whole. This includes appraising what was good about your work, as well as being appropriately critical. However, there is no obligation to find fault – being ‘critical’ simply means being ‘thoughtful’. This includes showing awareness of your own limitations at this stage of training, as well as any limitations which reflect the context within which you work. For example, while in an ideal world you might have talked to all members of a family, practical problems, or issue of confidentiality, might preclude this. A thoughtful discussion recognises these issues as realistic constraints. Setting unrealistically high standards for yourself or others would not be a good example of reflection.

Additional material which may be required

The results of standardised tests should be included in full in an appendix.

COMPULSORY REPORT: TRANSCRIPT-BASED THERAPY PROCESS REPORT

Aim
The aim is to show how you link the model of therapy you are applying to the process of the therapy you carried out. The core of the report is a reflective commentary, based on a transcript of your work.

Competencies to be demonstrated
The report allows you to demonstrate the ability to use clinical skills within a chosen and specified theoretical framework and provides evidence of your capacity to critically reflect on your own work as a clinical psychologist.

What the markers will be looking for
Although markers will be expecting the clinical material to demonstrate *basic* overall competence, this is not the main point of the report. The major focus lies with the commentary you offer, which will reflect on:

- what you were attempting to do
- how you did it
- any difficulties or issues which arose and
- the impact of the intervention both on you and on the client

Markers will pay particular attention to your ability to demonstrate links between the model you are using and the techniques you employ. As above, this does not mean that they expect you to apply them perfectly – only that you show an understanding of why you were doing what you did.

Content and suggested structure
a) Choosing appropriate material
Selecting appropriate clinical material is the critical initial step. You should be clear about the clinical themes and interventions you want to demonstrate, and be certain that the material will illustrate these.

It is best if material chosen for this report comes from a therapy which you are recording routinely. It is not helpful to record a sessions on a 'one-off' basis just to meet requirements for this report – both you and the client will probably be over-conscious of the recording process.

b) Choosing extracts from the recording
Usually the report will be based on a recording of a single clinical session. Given the word limit you cannot include all the material, so you will have to think carefully about what to include. The usual strategies are to:
a) identify extracts from across the session which exemplify the themes which you wish to draw attention to, *or*
b) select a continuous extract, again because it illustrates some relevant themes.

Alternatively you might want to focus on the way an important clinical issue or theme evolved over a number of sessions. On this basis, you could present short extracts from a series of sessions, rather than a single session. However, the extracts should be carefully chosen to illustrate both the clinical focus and its evolution.

Choosing appropriate extracts is important – they should be selected to illustrate the points you wish to make.

c) Overall structure of the report

i) Introduction

Start by outlining where the focus of the report will lie (and hence the reasons for choosing the extract(s)). For example:

This report will focus on a rupture in the therapeutic alliance, and the way in which this rupture helped to cast light on some important dynamics in the therapeutic relationship.

This report will focus on the use of guided discovery in the assessment of a client, and its value in helping to establish a more precise understanding of the client's problems.

After this you should outline the presenting problem (including a diagnosis where this is relevant), any other relevant issues relating to the client's background and the clinical context, and the assessment, formulation and intervention plan. You should identify the theoretical approach you are employing, and briefly review why you adopted this approach . You should also indicate the session number from which the extract is drawn (e.g. "this was the third session in a 15-session therapy"). In some instances it may be relevant to indicate the immediate treatment history that preceded the fragment you are presenting.

This outline should not be too long – the idea is to set the scene, and give enough information to orient the reader to the focus client/s and to the clinical material.

ii) Extracts and commentary

Extracts should be transcribed, and speaker turns numbered to facilitate cross-referencing.

In most (but not all) instances it will be best to integrate the commentary with the transcript. If you do this, it is important to make it easy to distinguish the transcript from the commentary by using a different font or italics (and see comment below regarding the word count and transcripts).

You should then comment on the transcript, describing the therapeutic process as you understand it. For example:

- What I was intending to do was to assess the meaning of X to the client, though this seems to have been heard in a very different way by the client, who…
- I was trying to maintain a collaborative framework for implementing guided discovery, but the client seemed to react angrily to what I had thought were gentle probes…
- The client's specific reference to X suggested that this would be a good point at which to make an interpretation that attempted to draw their attention to the relationship themes which were central in the formulation
- At this point the client seemed to withdraw into herself, and after what seemed a long silence I began to wonder if…

This commentary should track the transcript, trying to integrate:

- your sense of the therapy process and the skills you were employing
- your moment-to-moment intentions, e.g. "what I was hoping to do here was to shift the focus from X to Y"
- because I thought this might raise the client's anxiety if broached too directly, I thought I'd start by raising issue A rather than issue B
- the way in which your subsequent actions are adapted to the client's reactions.

It is very important that the commentary should indicate how your interventions relate to the model you are applying. For example, you may refer to the model to help explain why you did something, or how you understand the client's reactions to your interventions. Bear in mind that your sense of being informed by your model would also be illustrated by noting where (and why) you went "off model". You are not expected to adhere perfectly to a model all the time; models are intended to inform, not to be followed blindly.

The commentary should also be appropriately reflective: as well as noting what went well you should also identify what did not go as well as intended, and try to account for these more problematic moments. Bear in mind that a reflective commentary is not a matter of simple self-criticism; it is more a matter of conveying your understanding of the ways in which the intervention might have worked better – for example, suggesting a rephrasing that might have been clearer to the client, or identifying possible reasons why the client might not have picked up on your intervention in the manner which you expected.

You do not need to comment on *every* exchange between yourself and the client unless there is a good reason for focusing at this level of detail.

iii) Reflections

The final section of the report will be a reflection on the material as a whole. This should include points of future learning. It may also include reflections on, for example:

- the relationship between your intentions and the actual impact of your interventions
- your experience of trying to apply the specific theoretical framework
- any specific difficulties or dilemmas you experienced during the session
- how supervision informed the piece of work or decisions taken

Word count and transcripts

The word limit ***excluding*** the transcribed extracts is 3000 words. The transcript itself should be a minimum of 400 words and a maximum of 1000 words

Guidelines on the recording

Although you do not need to submit the recording with the report, the examiners can ask for a copy, and you should ensure that this is available should they request it. It should be of good quality and the dialogue should be clear and audible.

Gaining consent for recording

Recording a clinical session requires the informed consent of the client. They must be made aware that the recording and commentary will be listened to by supervisors and could be listened to by third parties at the University, and that this may include an external examiner.

Consent forms for recording and for the use of clinical material in a clincial report can be found on the course website.

The consent forms should be filed in the client's clinical notes. It should not be submitted with the report, as this would breach confidentiality by revealing the name of the client.

Safeguarding recordings - encryption: It is essential that steps are taken to safeguard the security and confidentiality of recordings by encrypting recordings. Because this cannot be done directly from the hard disc within the recorder you will need to transfer and encrypt the recording to a USB stick at the earliest opportunity, and delete the file on the recorder. Section 8, Appendix 5 identifies how this can be done.

Most Trusts insist on the use of encryption to assure client confidentiality – trainees should make sure that they follow local policy guidance.

Retaining the recording

Recordings should only be retained for as long as they are required. In the case of the recording on which the transcript report is based this means retaining it until it is clear that that an external examiner will not request it as part of an assessment for educational purposes – in practice at the end of the course.

OPTIONAL REPORT 1: SINGLE CASE STUDY

Aim
The report is intended to give trainees the experience of conducting and writing up a piece of clinical work using standard single case methods (these will be covered in your research methods lectures). The aim is to demonstrate a systematic approach to monitoring client change over the course of intervention, with frequent, possibly session-by-session, applications of a simple quantitative measure of the client's behaviour or main problem.

Competencies to be demonstrated
The report allows you to demonstrate the ability to conceptualise and report on a piece of clinical work within the single case framework.

What the markers will be looking for
The markers will be assessing the ability to design, conduct and report on an intervention using single case methods.

Type of clinical material appropriate to this report
A clinical problem or situation where systematic monitoring of client change is integral to treatment planning or intervention. The report should focus on a behaviour that can be quantified and measured regularly (usually by self- or other- observation) and should involve the application of a defined intervention. There will usually be clearly delimited baseline and treatment phases. The single case method may be applied in terms of a classic ABAB design, or could use another approach.

Examples of suitable pieces of clinical work include a parent training intervention to reduce a behaviour problem in a 4-year old child, a staff intervention to reduce challenging behaviour in a day centre setting for adults with learning disabilities, the acquisition of new learning for a client in a rehabilitation setting, or the monitoring of session-by-session change in a client with OCD.

Suggested content and structure
- a brief introduction to the general problem being addressed, with a review of relevant literature;
- a description of the clinical background, relevant cultural and contextual considerations, the details of the intervention, and a rationale for and a description of the methods of measurement;
- an appropriately developed formulation;
- the results of the intervention, including a graph of the data (statistical analyses are not usually needed);
- a discussion of the outcomes. This should include some consideration of causality – i.e. a discussion which considers whether the intervention itself was responsible for any change in the client/system;
- reflection on points of learning, including the utility of this approach in relation to the clinical work as a whole.

Additional material
There are no specific requirements, but additional material may be presented in an appendix if required.

OPTIONAL REPORT 2: ADVANCED ASSESSMENT REPORT

Aims

The aim of this report is to present a detailed account of a complex assessment, relating the work undertaken to psychological theory and outlining the implications of the assessment for clinical intervention.

Competencies to be demonstrated

This report allows you to demonstrate competency in assessing a reasonably complex clinical scenario or presentation, integrating material from a range of sources and relating this to theoretical knowledge, showing a capacity to disconfirm possible explanations for presenting problems (or at least attempting to do so) as well as an ability to identify confirmatory evidence for any hypotheses.

Often – though not invariably - the assessment will be part of a multidisciplinary approach and so this report also allows you to demonstrate competency in working as part of a multidisciplinary team. The report allows you to show that you have been able to:

- find a way to focus on the necessary questions
- gather a suitable range of information
- interpret the results of the assessment
- distinguish between alternative “explanations” for the presentation
- provide feedback and clear recommendations to the client, client's family, referrer, and/or other colleagues, as appropriate.

Criteria for the report (type of material)

A very straightforward assessment would not be acceptable – for example, it would not be appropriate to report on a single session assessment using a WAIS to determine cognitive functioning in an individual who is already known to have a learning disability.

The emphasis here is on an assessment which distinguishes between a number of non-trivial alternative explanations for a clinical presentation. For example:

- assessment of a child who is performing very erratically at school, where the aim is to answer questions about the factors which could be contributing to this picture

- assessment of a client in a CMHT with a long and complicated psychiatric history, where the aim is to clarify the nature of their presentation and hence to identify a treatment plan

- assessment of a person who is referred for “anxiety” and who presents with such a wide range of anxiety symptoms that it unclear what type of intervention is most likely to be of benefit, and where the aim of assessment is to arrive at a formulation which can be used to guide a focused treatment plan

Many (but not all) assessments will be carried out over a number of sessions.

Where an assessment is conducted in the context of team working the assessment process can include information from a range of sources, and also involve seeking the views of a range of workers who have had contact with the client or their carers.

What the markers will be looking for

The markers will want to see a detailed understanding of the theoretical and clinical issues raised by the referral, and (if relevant) of the multidisciplinary or service context within which the assessment takes place. There should be:

- a clearly identified set of aims for the assessment. This should include a description of the specific challenges posed by the assessment question
- (as relevant to the piece of work) appropriate use and interpretation of measures
- a demonstration of your capacity to integrate information (for example, 'triangulating' information from different sources/ informants, or integrating assessment information)
- a psychologically-informed interpretation of results

Overall you should demonstrate that you can use the findings of the assessment to produce useful clinical recommendations, and show how these can be, or have been, acted on.

Suggested content and structure

The report should include:

- A brief introduction and account of the referral and presenting problem
- Aims of the assessment and a statement about the specific challenges posed by the assessment question
- An overview of any relevant theoretical literature.
- A rationale for the initial plan for the assessment, describing what questions you aimed to answer, and why, and detailing the various sources from which information was obtained.
- A description of the assessment process(es)
- An account of the information obtained and any pertinent observations made during the assessment(s), including relevant cultural and contextual considerations
- An integration of this information to provide likely answers to the questions posed and/or a comprehensive psychological formulation.
- A discussion of the clinical recommendations arising from the assessment, and how these were taken forward.
- A critical reflection on the work undertaken.

All advanced assessment reports should include a description of the ways in which findings from the assessment were used – this is as important a competency as the assessment itself. For example:

- how did you give feedback to the client and/or carers?
- how was information shared with the team and how was this received/acted on by them

Additional material

A brief description of any standardised or observational measures used, and a summary of the client's scores (raw scores and standard scores), should be included as appendices.

OPTIONAL REPORT 3: THEORY-ORIENTED REPORT

Aim
The aim of this report is to show familiarity with the complexities of a particular theoretical orientation or framework.

Competencies to be demonstrated
This report allows you to demonstrate the ability to draw on psychological theory, at a reasonably sophisticated level, to understand clients' clinical presentation and to inform your practice.

What the markers are looking for
The report will be evaluated in terms of the quality and sophistication of the theoretical framework which you are able to bring to the clinical issue you identify. The markers will therefore want to see that:

- you can use the theoretical ideas to explain important clinical observations
- you can use the theory appropriately
- evidence associated with the theory is appropriately considered in relation to the clinical material
- your understanding of the clinical material is deeper as a consequence of this theoretical consideration
- the limitations of the theory are accurately and appropriately identified

The presentation of the theory itself separately from its integration with the clinical material is not an important part of the assessment – in other words credit would not be given for descriptions of the theory that were not related to the clinical material.

Type of material
Any type of clinical work would be suitable and any kind of clinical problem could be the subject of the report.

Suggested content and structure
The report should briefly outline the theoretical framework to be used. If relevant to the material presented, it may be appropriate to identify any controversies concerning its status (for example, if the approach you adopted is not usually applied to the client group you are describing, or the evidence base for its use is very limited).

The report should start with a description of the client, relevant cultural and contextual considerations, and the clinical problem that is to be addressed. The main focus of the report should be an integrative discussion of how the chosen theory illuminates aspects of the clinical material – for example, the presentation, history, associated factors, the process of therapy or the outcome of intervention. They key word here is “integrative”, showing how theoretical ideas illuminate the clinical material and aid understanding, and the ways in which the theory helped the actual work.

The report should conclude with critical reflections, including points of learning. If there are aspects of the clinical material that are inconsistent with the theoretical formulation, this should be discussed and reflected upon, whether this reflects a concern with the application of the theory, or suggests limitations of the theoretical framework under consideration.

Additional material required
There are no specific requirements, but if necessary additional material may be presented in an appendix.

OPTIONAL REPORT 4: A COMPLETED CLINICAL INTERVENTION

Aim

This report offers an opportunity to discuss in detail a whole treatment - from planning to implementation, and hopefully to follow-up, highlighting the decisions made and steps taken. The aim is to give evidence of your clinical reasoning and it is particularly important to highlight your thinking about your work and the considerations which have led you to make specific choices at specific times.

Competencies to be demonstrated

The report allows you to demonstrate the ability to report clearly on your clinical work, describing the decision-making processes that you followed and the way in which these informed both the design of the intervention and its subsequent adaptation in the light of the client's response.

What the markers are looking for

The clinical report is evaluated on the basis, not of the success of the work undertaken, but of the clarity and coherence of reporting of clinical material. It gives you an opportunity to demonstrate your capacity to describe:
a) the process of clinical decision-making that leads to the design of a treatment intervention;
b) the ways in which this intervention is re-appraised and modified in the light of the client’s response.

While it is important for you to demonstrate that your work was guided by a particular conceptual framework, the *detailed* presentation of that framework need not be part of the report. Evidence of knowledge of the framework is expected to be implied by the decision making process described. Evaluation will focus on the clarity of reporting of clinical experience, the level of clinical thinking (both prospective and retrospective) reflected in the report, and the appropriateness and sophistication of the clinical interventions described (including the capacity to respond to unexpected consequences of clinical decisions).

Type of material

Any clinical intervention, whatever its outcome, in which you have been involved throughout the whole process from assessment to follow up, should provide appropriate material for this kind of report.

Suggested content and structure

Normally the report will contain the following components, though the structure may vary somewhat, depending on the theoretical orientation of the report:

- Brief introduction and background to the referral
- Description of cultural and contextual considerations;
- Initial ideas and hypotheses concerning the presenting issues, and assessment procedures implemented to confirm these hypotheses
- Conclusions based on the assessment, and your initial formulation of the clinical presentation or presenting problems
- A detailed report of the intervention. If relevant, you should also describe any ways in which your thinking was modified as information emerged from the treatment – for example, how initial hypotheses were reframed or formulations revised.
- Brief report of outcome
- Reflection on the work as a whole

Normally the background information would be kept to a minimum and your clinical thinking both during and after the intervention would be given the most weight.

OPTIONAL REPORT 5: AN IMPASSE IN A PSYCHOLOGICAL INTERVENTION

Aim
The aim of this report is to focus on a piece of clinical work where there were significant difficulties in implementing an intervention. There are various dictionary definitions of an 'impasse' - for example, a situation that is so difficult that no progress can be made; a deadlock or a stalemate. The word ‘impassable’ is derived from the word impasse – to mean (for example) a road or passage having no obvious exit; like a cul-de-sac.

In the context of psychological interventions the word ‘impasse’ is used to indicate that a major obstacle has emerged which, if not addressed, could represent a major threat to the maintenance of therapeutic contact.

Examples of an impasse might be:

- a client who had been making good and steady progress who suddenly becomes angry and sullen for no reason that you can (initially) detect
- a client who has been attending regularly who starts missing sessions for no clear reason
- a client who readily agrees to carry out behavioural experiments in the session, but never carries them out in practice
- a client who says they can only continue if you are able to be a friend to them, rather than a therapist

Impasses are not simple perturbations in the therapy – for example a single incident where the client seems puzzled about something and you resolve matters very quickly. An impasse is usually a major impediment that could derail the therapy if not attended to.

Competencies to be demonstrated
The report allows you to demonstrate skills in managing impasses in clinical work, including the ability to recognise such situations as they arise, to use your theoretical knowledge and clinical experience to understand the possible reasons underlying these developments, to identify an appropriate course of action, and to reflect on the work undertaken.

What the markers are looking for
Because this report focuses on the management of impasses, a good report will demonstrate competence in the capacity to:

- recognise the presence of an obstacle to implementation of an intervention;
- draw on relevant academic and clinical knowledge in order to understand the nature of the problem, and to derive a working formulation of the issues;
- translate this formulation into a set of actions appropriate to the clinical context;
- articulate the above in a coherent and reflective manner, including any broader implications for clinical practice.

Type of material
Examples of relevant situations could include work where:

- major challenges to the therapeutic alliance emerged
- a client's complex social problems made the delivery of the psychological intervention problematic
- the client aroused strong personal feelings in you as therapist, with implications for your capacity to deliver the intervention
- indirect interventions were threatened by the antipathy of a staff team
- serious difficulties emerge in applying the theoretical model being adopted

Although many impasses emerge only when treatment is under way, reports could also cover instances where major obstacles to engagement had to be surmounted before an intervention could begin, and where intervention based on an understanding of these obstacles was critical in sustaining contact. They could also consider situations where it becomes clear that difficulties in implementing an intervention indicated the need for a major revision in the approach taken.

Reports that discuss unresolved impasses will be as welcome as those where the impasse is overcome.

Suggested content and structure

This report will usually:

- provide a brief introduction;
- identify the nature of the impasse and review relevant clinical and theoretical literature;
- describe the clinical context within which the impasse developed;
- provide an account of relevant cultural and contextual considerations;
- offer a formulation or hypotheses about why the impasse has emerged;
- describe the ways in which resolution of the impasse was attempted; and
- provide critical reflections, including a consideration of the outcome and any further steps that may be recommended or proposed.

Additional material required

There are no specific requirements, but if necessary, additional material may be presented in an appendix.

OPTIONAL REPORT 6: INTER-PROFESSIONAL AND/OR INTER-AGENCY WORKING

Aims

The aim of this report is to present a detailed account of an intervention where work with individuals from other professionals was central, or played a significant role in the intervention.

Criteria for the report (type of material)

It is important to choose a piece of work where inter-professional or inter-agency working was important, rather than incidental, to the work, and where there is sufficient material to explore the ways in which the interdisciplinary nature of the work influenced progress.

The work may have involved close liaison with other professionals in a multi-disciplinary team, with several professionals actively contributing to work with an individual client, or may have involved working across different agencies (for example, with workers based in different statutory settings. Reports could of course encompass both inter-professional and inter-agency working.

Competencies to be demonstrated

This report allows you to demonstrate competency in inter-professional or inter-agency working, showing an awareness of common challenges to, and benefits of, this way of working (for example, because of differences in staff roles, assumptions and values), and identifying the impact of this way of working (for good or ill).

The report allows you to show that you have been able to:

- understand the roles and hence potential contributions of other professionals, drawing on this knowledge to work as effectively as possible with colleagues in the interests of the client
- identify and work with any legal and professional issues that arise in the course of the work (for example, around confidentiality and information governance)
- assess (and formulate) the reasons for any barriers to effective work
- identify any strategies used/implemented in order to manage the work/ mitigate any barriers to effective working
- contribute to the team or to the work of other agencies through verbal and/or written communications

What the markers are looking for

The markers will want to see a detailed understanding of any theoretical, clinical and professional issues raised by the multidisciplinary or service context within which the work takes place. There should be:

- a clear description of the service context(s) and the professionals involved in the work (in other words, the ‘system’ within which the intervention is taking place)
- a demonstration of your capacity to integrate information (for example, ‘triangulating’ information from different sources/ informants, or integrating assessment information)
- a demonstration of your contribution to the work of other professionals/agencies

Suggested content and structure

The report should include:

- a brief introduction
- an account of the context for the work, including the referral (or the ‘route’ taken by the client such that they are being looked after by the team)
- an account of cultural and contextual considerations that informed the work

- a description of the clinical work being undertaken (describing the nature of the client's problems and the approach the service is taking towards them),), including a clear account of your role and contribution to the work
- a description of the formal (and informal) relationships between the professionals involved in the clinical work
- a description of the ways in which the team or agencies formulated the problem and the actions required to manage these (including differences of view)
- an account of the way that the work developed and the roles different professionals played in its execution
- a description of how the functioning of the inter-professional/ inter-agency system promoted or impeded the efficacy of the work
- a description of how the clinical work progressed and any outcomes from this work
- a critical reflection on the work undertaken.

OPTIONAL REPORT 7: A REPORT OF A CONSULTATION WITH EXPERTS BY EXPEREINCE/CARERS[2]

Aims

The aim of this report is to present a detailed account of a consultation with experts by experience (who could be direct consumers of health care, carers, or representatives from expert by experience/service user/carer organisations).

The experts by experience who are consulted should not be recipients of direct clinical services provided by the trainee.

Competencies to be demonstrated

This report allows you to demonstrate competency in setting up a consultation with experts by experience that promotes respectful engagement and learning from them, while helping you to understand the issues and values that are important to them, and the implications of these for service delivery and service development.

The report allows you to show that you have been able to:

- set up a consultation designed to help you and your service understand the perspectives of experts by experience, and that enables experts by experience to present their ideas as experts and/or equal stakeholders
- implement and facilitate a collaborative discussion
- derive a coherent account of the perspectives and values of experts by experience
- relate the ‘position’ of the experts by experience to the viewpoint/assumptions of the professional ‘system’ within which service users are being seen, and formulate reasons for any differences
- reflect on and apply any conclusions/implications from the consultation to your own practice as well as that of the professional service
- where relevant, disseminate insights/ information from the consultation to the service in a professional and constructive manner

Criteria for the report (type of material)

It is a good idea to choose consultations where contact with experts by experience/service users or carers has been meaningful, for example because it has contributed to a better understanding of service needs and service delivery, or has implications for service redesign (which could mean small but meaningful adjustments as well as suggestions for more significant change).

What the markers are looking for

The markers will want to see a detailed understanding of any theoretical, clinical and professional issues raised by the consultation. They will also be looking for:

- an account of the rationale for, and purpose of, the consultation
- a description of how the consultation was set up, along with its format and content
- any ‘insights’ gained as a result of the consultation and how these might be taken forward/ disseminated

Suggested content and structure

The report should include:

- a brief introduction
- a description of the service context
- a description of cultural and contextual considerations
- a description of the issues that prompted the consultation
- a description of the way the piece of work has been conceptualised

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[2] Course expectations regarding service user consultations are detailed in the Training Handbook

- a description of how the consultation was set up (including any relevant correspondence), and the rationale for the approach taken
- a description of the ways in which relevant ‘ground rules’ were negotiated with the experts by experience (e.g. around confidentiality, or the way in which feedback would be given)
- a description of the procedures used to garner information, including any systematic procedures
- a description of the conclusions drawn from the consultation
- a description of the process of giving feedback from the consultation (both to experts by experience as well as the service)
- if relevant, an account of any planned changes made on the basis of the consultation
- if relevant, any formal/informal evaluation of the impact of these changes
- reflections on the consultation process

Where relevant the report should also describe any changes in service delivery/service design consequent on the consultation.

OPTIONAL REPORT 8: A REPORT OF A PIECE OF ‘LEADERSHIP’ WORK

Aims
The aim of this report is to present a detailed account of a piece of leadership work, which may be conducted within teams or organisations.

Competencies to be demonstrated
This report allows you to demonstrate competencies in a range of areas, depending upon the context in which you are working. This would be very different in a policy context and a managerial/business context, or an NHS or social enterprise context, for example.

The report allows you to show that you have been able to implement at least some of the following leadership competencies (you will not be expected to demonstrate ALL of the following - markers will use their judgement as to which are most relevant to the piece of work you are presenting):

- identify the contexts for change
- demonstrate awareness of the political, social, technical, economic, organisational and professional environment
- understand and interpret relevant legislation, accountability frameworks, policy, and existing evidence
- anticipate and prepare for the future by consulting key stakeholders regarding ideas, best practice, and/or emerging trends that will have an impact on the key outcomes for the team/organisation
- use appropriate methods to gather information
- influence others to use knowledge and evidence to achieve best practice
- use information to challenge existing practices and processes
- participate in and contribute to organisational decision-making processes
- educate and inform key people who influence and make decisions
- contribute a psychological perspective to team, department, system and organisational decisions
- identify barriers and to implementation and potential solutions
- formally and/or informally disseminate good practice
- recognise and articulate your own values and principles, understanding how these may be different from those of others
- identify your own strengths and limitations, and the impact of these on others

The above list is not an exhaustive list of leadership competencies. For further information on competencies that may form part of this report, please see the Clinical Psychology Leadership Development Framework (DCP, 2010).

Criteria for the report (type of material)
Examples of relevant work could be:

- arriving in a new team and conducting a scoping exercise on their needs, proposing a within-service change, negotiating this with key stakeholders and carrying it forward (or how this was left upon departure from the service so that it could be taken forward)
- taking forward an initiative proposed by a supervisor or senior figure within the organisation, including how you assessed its relevance, researched and/or negotiated it within the team, and carried it forward
- setting up an initiative relevant to the work of clinical psychologists or the client groups served by clinical psychologists (inside or outside of placement)

If the report is written on work carried out as part of training but outside of a placement context (e.g. work for the doctoral training programme), it can be signed off by another qualified psychologist who can verify the work.

What the markers are looking for

The markers will want to see a detailed understanding of any theoretical, clinical, professional and policy issues raised by the piece of work. They will also be looking for:

- an account of the rationale for, and purpose of, the piece of work
- a description of how the work was set up, along with its format and content
- any ‘insights’ gained as a result of the work and how these might be taken forward/ disseminated

The work does not need to be ‘perfect’. Indeed, much can be learned from apparent ‘mistakes’ and the identification and overcoming of obstacles, and this can be reflected upon in the account.

Suggested content and structure

The report should include:

- a description of the organisation and/or policy context
- a description of the issues that prompted the work
- a description of how the piece of work was set up (including any relevant correspondence), and the rationale for the approach taken
- a description of the ways in which relevant ‘ground rules’ were negotiated with the participating individuals and/or organisations (e.g. around confidentiality, or the way in which feedback would be given)
- a description of the procedures used to garner information, including any systematic procedures
- a description of the conclusions drawn from the work
- a description of the process of disseminating insights arising from the work
- if relevant, an account of any planned changes made on the basis of the work
- if relevant, any formal/informal evaluation of the impact of these changes
- reflections on the process

Where relevant the report should also describe any changes in service delivery/design, organisational change, and/or policy consequent on the piece of work.

You may draw upon a variety of theoretical material which includes but is not limited to:

- clinical models and methods applied in organisational contexts
- organisational psychology
- management and economics texts

SECTION 22: PROGRAMME REGULATIONS

ASSESSMENT PROCEDURES AND

THE ROLE OF THE BOARD OF EXAMINERS

This section gives an overview of programme regulations and assessment procedures, and the role of the Board of Examiners in overseeing these procedures.

It includes information about:

- entrance qualifications for the Course
- the structure of the Course
- the ways in which academic, clinical and research competences are assessed
- the number of times failed course components can be retaken
- how the Board of Examiners is constituted and how it carries out its functions
- procedures for appealing against a decision of the Board of Examiners

Trainees can find more detailed information about procedures used for passing and failing each area of the course in Sections 24 to 27 of this handbook.

The Board of Examiners overviews trainees' progress and is empowered by the University to make decisions about whether trainees have passed or failed the Course. It does so by considering whether they have fulfilled course requirements, and in reaching its judgments takes into account any relevant extenuating circumstances or the outcomes of any appeals procedures.

PROGRAMME REGULATIONS FOR THE DEGREE OF DOCTOR IN CLINICAL PSYCHOLOGY (D.Clin.Psy.)

These regulations should be read in conjunction with the Academic Regulations for: Professional Doctorates. These can be found on the Registry website, at:

https://www.ucl.ac.uk/academic-manual/sites/academic-manual/files/chapter_5_part_b_professional_doctorate_regulations_2020-21.pdf

1. Entrance Qualifications

1.1 The normal minimum entrance qualification for registration for the degree of Doctor in Clinical Psychology is an upper second class honours degree with Psychology as the main field of study, or an appropriate Master's Degree or Diploma, qualifying the applicant for Graduate Basis for Chartering (GBC) with the British Psychological Society. Applicants should also have at least one year's relevant clinical experience. In exceptional circumstances (and subject to the approval of the authorities of the College), consideration may be given to those without such clinical experience.

2. Duration of Programme of Study

Full-time: three calendar years

3. Curriculum

3.1 The course of study for the degree of Doctor in Clinical Psychology includes formally taught and practical elements, which provide academic and clinical underpinning for the research undertaken. Candidates are required to complete four case studies, one piece of service-related research and undertake a substantial piece of research resulting in a thesis.

3.1.1 *Formally Taught Elements*

The teaching programme will cover methods of clinical psychological research, statistics and basic research on the psychological models of clinical disorders, methods of assessment and interventions in a range of clinical areas.

3.1.2 *Practical Experience*

Candidates will be expected to acquire supervised clinical experience with a number of clinical populations in accordance with the requirements of the Health Professions Council (HPC) and the British Psychological Society (BPS) which would qualify successful candidates to become eligible to apply for registration with the Health Professions Council and for recognition as a chartered Clinical Psychologist with the BPS.

3.1.3 *Case Studies and Service-Related Research*

Three case studies and one piece of service-related research, which shall total approximately 13,000 words, shall be completed.

3.1.4 *Thesis*

The length of the thesis shall be approximately 25,000 words, with a maximum of 40,000 words.

The overall research submission (3.1.3 and 3.1.4) shall illustrate the candidate's ability to apply scientific psychological principles at various levels of application of clinical psychological knowledge.

4. Assessment and Oral Examinations

4.1 All assessments, including the assessment of clinical competence, will be overseen by examiners external to the University.

4.2 Written examinations qualifying a candidate for submission of the thesis will take place in the first two years of the course and will comprise:

(i) a 3-hour written examination in year 1, assessing the theory and application of clinical psychological methods;

(ii) a 2-hour written examination in year 1, assessing competence in research methods;

(iii) a 3-hour written examination in year 2, assessing the theory and application of clinical psychological methods at an advanced level;

(iv) a 3-hour written examination in year 2, assessing competence in statistics.

4.3 A candidate failing any examination in the first or second year will be required to sit and pass an equivalent examination in August or September of the same year.

4.4 Clinical competence will be monitored throughout the clinical placements and will be assessed by examiners at the end of each 6-month placement period.

4.5 If a candidate fails to satisfy the requirements of a clinical placement, an oral examination will be conducted by at least two examiners, one of whom will be external to the University. The examination will cover clinical work undertaken during the placement and will be designed to test the candidate’s ability to integrate theory, research and clinical practice at a level appropriate to their year of training. The possible outcomes of the oral examination are:

i. Assessed placement period passed
ii. Assessed placement period passed but with stipulated requirements for the demonstration of specific competencies in subsequent placements
iii. Assessed placement period failed

4.6 Candidates must pass six placement periods in order to pass the Programme. If a placement period is failed, candidates will be normally be permitted to undertake an additional placement period (though this will be at the discretion of the Examination Board). A candidate will be deemed to have failed the Programme if s/he fails more than one placement. Candidates will only be allowed to undertake one additional placement period during training.

4.7 The three case studies will demonstrate a knowledge of psychological theory and its application to clinical work. The service-related research report will demonstrate an ability to conduct applied research in clinical service settings. Two case studies, or one case study and the service-related research report, will be submitted in year 1. The service-related research report (or case study, if the service-related research report was submitted in year 1) will be submitted in year 2. The final case study will be submitted in year 3. A candidate who fails any piece of work (case study or service-related research) will be required to demonstrate the relevant competencies by submitting a new, equivalent piece of work. If the resubmission fails to satisfy the requirements, the candidate will not be permitted to continue on the course. Details on the timing of the resubmission will be announced by the course tutors.

4.8 The thesis will make a distinct contribution to the knowledge of the subject and will afford evidence of originality shown by the discovery of new facts and/or the exercise of independent critical power. It will be examined by an oral examination, which will be conducted by at least two examiners, one of whom will be external to the University. The examination will be designed to test the thesis against the criteria stated above. The possible outcomes of the oral examination are:

(i) Pass
(ii) Pass conditional on minor corrections (one month)
(iii) Referred for stipulated revisions (three months)
(iv) Referred for major revisions (one year); a further oral examination, following resubmission, may be held at the discretion of the examiners
(v) Fail: no resubmission permitted

4.9 The award of the degree will be dependent on a satisfactory defence of the thesis in the oral examination as well as successful completion of all the other elements of the course as detailed above.

4.10 All elements of the course must be completed within four calendar years. In exceptional circumstances, this may be extended at the discretion of the examiners.

4.11 Where a student’s behaviour or actions gives rise to concerns about their Fitness to Practise they will be subject to the UCL School of Life and Medical Sciences procedures for the assessment of Fitness to Practise in a Professional Capacity.

5. Dates of Assessments and Oral Examinations

5.1 Written examinations qualifying a candidate for submission of the thesis will take place in the third term in year 1, and in the third term of year 2. Dates will be announced annually by the course tutors. Assessment of clinical competence, including an oral examination when necessary, will take place at the end of each 6-month placement period. The three clinical reports and the service-related research report will be submitted as detailed in paragraph 4.7 above; dates will be announced annually by the course tutors.

5.2 The thesis will be submitted in June of the third year of study and will be examined by the end of September. Dates for the submission and examination of the thesis will be announced annually by the course administrators. Final copies, including minor amendments to the thesis specified by the examiners, must be submitted in the period defined by the examiners, at which point the course can be passed and HCPC registration arranged.

5.3 In the third term of the third year of the course of study, a candidate may defer submission of his/her thesis submission. In this case, examination of the thesis will be negotiated ad hoc to take place within three months of submission, subject to finding suitable willing examiners.

THE ROLE OF THE BOARD OF EXAMINERS

The Board of Examiners receives information about each trainee’s progress on the Course, and ratifies decisions about whether each item of coursework is passed or failed. It considers the appropriate actions to take when progress is not satisfactory, and interprets the regulations in order to reach decisions about trainee’s progression on the Course (for example, considering the impact of extenuating circumstances on trainee’s performance).

Composition

The Board of Examiners comprises Course staff (who act as internal examiners) and External Examiners (who are appointed by the Course, and approved by the University as individuals whose experience and qualifications are appropriate to this role). Because of the size of the Course there are a large number of External Examiners. Their role is to moderate standards (in other words, to ensure that standards at UCL are commensurate with standards on other courses). They do this by seeing representative samples of trainees’ coursework, and/or by participating in viva examinations (both of the thesis and clinical placements).

Frequency of meetings

The Board meets several times a year in order that it can deal with specific diets of examination or assessments in a timely manner. The full Board meets once a year (in September); at other times a sub-Board meeting is held.

All the work required for each academic year should be submitted and available for consideration by the September meeting of the Board of Examiners.

Role of the Board in relation to passing and failing

Candidates will be referred to the Board if:

a) they receive a mark of 'Fail' on a case report or the service-related research report, or
b) two instances in the same academic year of a case report receiving major revisions, or
c) they receive a mark of 'Fail' in the research component of their dissertation, or
d) their performance in any of the unseen papers in the examination is marked as a fail, or their performance is a bare or a low pass, or
e) if their supervisor indicates that there is a substantial risk that a placement will not be passed at any point in the placement, or
f) if their supervisor refers them to the Board at the end of placement
g) if there are reports of major breaches of professional standards on placement or elsewhere and/or concerns about fitness to practise

The Board will consider each trainee’s case and decide what training requirements may be necessary to ensure that the candidate has met the minimum criteria for practice as a clinical psychologist.

Once a candidate is referred to the Board of Examiners on clinical or academic grounds, entry to the succeeding year, or completion of the course in the final year, will be at the discretion of the Board of Examiners. This may depend upon further assessment by means of viva, additional coursework, and/or examination.

All the specified academic and placement requirements for each year must be completed satisfactorily before entry to and registration for the succeeding year is permitted, or (in the final year) a qualification can be awarded.

Notification of results to students

The Board reports the recommended results to the Examinations Section of the Registrar's Division after the relevant meeting. Formal notification is sent from the Registry to each student.

Extenuating Circumstances

Extenuating Circumstances (ECs) are defined by UCL as "events which are sudden, unexpected, significantly disruptive and beyond your control and which may affect your performance at summative assessment". Common examples include illness, bereavement, or some practical impediment on placement that delays producing a clinical report. The UCL webpages on ECs contain detailed further information on this.

Trainees can submit EC claims to request mitigation. Usually this involves asking for an extended deadline on an assessment or, occasionally, the deferral of an exam.

For all examinations and clinical reports (including the Service-Related Project), EC requests need to be submitted via Portico**.** A guide to using Portico to submit claims is available here.

For other pieces of work (e.g. project proposals, thesis hand-in, or work related to the BABCP pathway), mitigation requests are handled internally.

If trainees know in advance that significant personal circumstances might seriously impact on their ability to sit an exam, it is essential they discuss this with their course tutor prior to submitting an EC claim. If extenuating circumstances took effect suddenly and unpredictably, trainees should contact the course as soon as possible and arrange to meet with their course tutor to discuss a formal EC procedure after the exam.

Complaints

Section 30 of this handbook gives details of the procedures for complaints across all domains of the training.

SECTION 23: PLAGIARISM AND ARTIFICIAL INTELLIGENCE (AI)

Plagiarism refers to passing off someone else's work as your own. It is a serious offence with potentially serious consequences.

Plagiarism can be both intentional and unintentional (where students do not understand what does and doesn't constitute plagiarism)

UCL offers very clear guidance on plagiarism: (https://www.ucl.ac.uk/students/exams-and-assessments/academic-integrity)

UCL also offers clear guidance on the use of AI tools in assessment here and here. Misuse of AI in assessments is considered to fall under the category of plagiarism and falsification. Passing off AI-generated content as your own work is a form of academic misconduct.

Assessments at UCL are categorised according to how AI tools may be used:

- **Category 1: AI tools cannot be used**
- Category 2: AI tools can be used in an assistive role
- Category 3: AI has an integral role.

All assessments in the Professional Doctorate in Clinical Psychology fall under Category 1 (AI tools cannot be used). The reason for this categorisation is that course assessments are designed to test competencies in critical thinking, knowledge application and clinical practice, which are essential and fundamental to working as a Clinical Psychologist. Students believed to have ignored the categorisation will therefore undergo the standard academic misconduct procedure.

Note that in UCL's Language and Writing review in the Academic Manual (9.2.2b), it is permissible for a third party to “check areas of academic writing such as structure, fluency, presentation, grammar, spelling, punctuation, and language translation.” However, “this may be considered Academic Misconduct if substantive changes to content have been made by the reviewer or software or at their recommendation.”

SECTION 24: PROCEDURES RELATING TO PASSING AND FAILING EXAMINATIONS

Marking

Examination papers are ‘blind’ marked by an internal examiner - examiners do not know the identity of the candidates. Each exam question is marked separately; the overall mark for the paper is arrived at by taking the average of the marks for each individual question. Guided by UCL’s Academic Regulations for marking of examinations, all scripts which the first examiner assigns a fail or a total mark between 50% and 60% (across the entire exam) script will be second marked by an internal examiner. Subsequently the two examiners must agree a mark. In the event that agreement is not achieved, the Chair of the Board of Examiners will assign a third marker. All cases assigned a fail at any point will be reviewed by an external examiner who will have access to the examiners’ comments. The external examiner appointed for the paper will also review the marks awarded overall and the marks awarded to a sample of scripts across the range of marks. This ensures that marking standards are fair, and in line with the standards applied on other courses.

Marks are awarded for each question, and a final pass or fail mark is given on the basis of the mean across all answers, with an overall mean mark of 50 required to pass.

Percentage	**Notes to guide examiners**
70+	Excellent answer Thorough and coherent answer, showing depth of understanding of the topic. No significant error or omission.
60-69	Strong answer Good understanding of the topic. Well organised and well expressed answer. May have minor errors and/or omissions.
50-59	Acceptable answer Satisfactory understanding of the topic. In general coherently expressed but not enough detail or sufficiently well-argued to be considered for a mark of 60+. Some errors and/or omissions.
40-49 (Fail)	Limited answer Some appropriate material but misses substantial important contents. Presented in a superficial manner and/or incoherently expressed. Significant errors and/or omissions.
30-39	Inadequate answer Very limited understanding of the topic. Some relevant information but fails to answer the question. Presented in a superficial and/or incoherent manner. Major errors and/or omissions.
<30	Seriously inadequate answer Virtually no relevant contents. Completely fails to answer the question.

Artificial intelligence (AI)

UCL assessments are categorised according to how AI tools may be used. Like all assessments within the Professional Doctorate in Clinical Psychology, examinations fall under **Category 1: AI tools cannot be used.** Use of AI tools within examinations therefore falls under UCL’s academic misconduct policy, and there is more in Section 23 of the course handbook. As outlined in UCL guidance, staff should not use AI detection software to check work, where there is suspicion that AI has been used. Instead, markers should discuss their concerns where needed with relevant course or module leads, the Assessment Team or the Academic Director.

Feedback of results
After the marks have been ratified by the Examination Board, trainees will receive notification of the outcome of the examination through Portico.

The overall outcome of the examination is Pass/Fail, and the marks for individual answers are not recorded on the transcripts or Portico, and therefore are not released to trainees.

Procedures for candidates who receive an overall mark of "fail"
Scripts which receive an overall mark of "fail" will be discussed by the Board of Examiners. The candidate will automatically be required to re-sit the paper. This must be passed in order for the candidate to continue on the course.

Complaints
Section 30 details complaint procedures. Briefly, trainees with concerns about the procedures which have been followed in marking their exams should initially raise this with the Chair of the Examination Board, who will consider the complaint and the steps to be taken, usually in conjunction with the Course's head external examiner. If trainees are not satisfied by the outcome of this internal procedure they can invoke the UCL complaints procedure.

UCL's complaints procedure can be found here: https://www.ucl.ac.uk/academic-manual/chapters/chapter-6-student-casework-framework/section-8-ucl-student-complaints-procedure

SECTION 25: PROCEDURES RELATING TO PASSING AND FAILING CLINICAL REPORTS AND THE SERVICE RELATED RESEARCH REPORT

Submission deadlines
Deadlines for submission will be published on the course website at the start of each academic year. All work must be submitted by **10 am on the date required**. Coursework submitted after the deadline, and without an approved extenuating circumstances claim, will be deemed to have failed and a new piece of work will need to be submitted in place of the original.

Extensions relating to a Summary of Reasonable Adjustments (SoRA)
You can find detailed guidance relating to adjustments to submission deadlines under a SoRA in UCL's disability support pages and in the Academic Manual. Trainees with SoRAs are automatically eligible for a **one-week extension for all clinical reports,** and a **two-week extension for the Service-Related Project** but should e-mail Sharinjeet to declare their intention to use the SORA to receive this extension so that the deadline can be updated on the system. Extensions will not be applied unless an e-mail request is received.

Trainees who have a SoRA and require a further extension due to extenuating circumstances should in addition follow the procedure below.

Extensions relating to Extenuating Circumstances
Extenuating circumstances (EC) may mean an extension can be negotiated for the date by which work must be handed in – this may be the first submission date, or the date for stipulated revisions. EC are defined by UCL as "events which are sudden, unexpected, significantly disruptive and beyond your control and which may affect your performance at summative assessment." All claims must be submitted through UCL's formal mitigation process via Portico. The relevant UCL webpages and the assessment section of the course website contain further information on this.

Common examples of EC include serious illness or major life events, and extensions are not granted due to pressure of work or minor ailments. In the case of clinical reports, another example of reasonable grounds for an extension would be unavoidable practical impediments on placement that cause delay (eg. where a crucial session for a report has been postponed until after the submission deadline).

Extensions of up to one week (Clinical Reports) or two weeks (Service-Related Project):
These can be "self-certified" (i.e. submitted without supporting evidence such as a medical certificate). Self-certifying mitigation requests do not need to be discussed with course tutors, and must be submitted prior to the date at which the work is due to be handed in. Reasons for self-certifying requests **must** meet the criteria outlined above – pressures of work or minor ailments are not sufficient groups for approval. Each individual extension can only be up to one week in length in the case of Clinical Reports, or two weeks in length in the case of the Service-Related Project.

You can self-certify for up to two separate periods of up to two weeks (ten working days) within an academic session (i.e., an academic year). If you have received two self-certified extensions within an academic year, any subsequent extension requests within that year must be accompanied by supporting evidence.

Extensions longer than one week (Clinical Reports) or two weeks (Service-Related Project):
These need to be accompanied by supporting evidence, and should be discussed in advance with course tutors at the earliest opportunity. Tutors will be able to advise on the types of mitigation available and required supporting evidence. Trainees who have already received

two self-certified extensions within an academic year must also provide supporting evidence for any subsequent extension requests within that academic year.

Retrospective requests: In certain exceptional circumstances, it may be possible for mitigation to be applied retrospectively after a deadline has passed. Any such request should be discussed with the course tutor, and usually submitted no later than one week after the deadline. All retrospective EC requests **must** be accompanied by supporting evidence.

Trainees with a Statement of Reasonable Adjustments (SoRA): You can find detailed guidance relating to adjustments to submission deadlines under a SoRA in UCL's disability support pages and in the Academic Manual. Trainees can receive EC-related extensions in addition to those already conferred by the SoRA. For this, they must follow the relevant procedures above using the Portico system. In the case of Clinical Reports, this would result in an overall two-week maximum self-certified extension (one week for SoRA and one week for EC). In the case of the Service-Related Project, this would result in an overall four week maximum self-certified extension (two weeks for SoRA and two weeks for EC).

Procedure for submitting reports

Clinical reports should be submitted as a Word file in the appropriate Moodle folder (e.g. 'Assignments: Clinical Report 3').

We will only require electronic submission via Moodle; no paper copy is required.

The Clinical Report should include a front sheet, stating:

- The type of report (e.g. "Clinical Report 1: Assessment Report", or "Clinical Report 3: Service Related Project", etc.)
- The title of the report
- The word count
- The date
- Your Clinical Report number (e.g. W13)
- A formal statement regarding confidentiality, as follows: "all names used in the report have been changed in order to preserve confidentiality"
- A statement indicating whether or not client consent was sought/obtained for the report, and (if consent was not sought), a brief indication of the reasons for this.

To ensure that the markers can blind mark, **please make absolutely sure that you name is not included in either the file name or the saved document– instead make sure that you name the file with your Clinical Report number (e.g. T30_CR5).**

Using "Turnitin"
As is the practice in many institutions, the course uses Turnitin (a plagiarism-detection programme) for clinical report submission. Trainees should read the student guide on using Turnitin - it contains further explanations of plagiarism, and instructions on how to use the programme: https://library-guides.ucl.ac.uk/referencing-plagiarism/turnitin

Naming files: When uploading your report, the filename inserted into the 'Submission Title' field is the Clinical Report submission and your designated Clinical Report code, for example, CR1_P23. You must not include your name because this would identify you to the markers.

Checking for plagiarism: Turnitin is being used to encourage good academic practice and referencing, not to catch trainees out. For this reason the system has been set such that trainees can submit their clinical report, look at the Turnitin report to identify any sections where they may be at risk having inadvertently plagiarised, delete the submission and submit a revised report.

Resubmissions can be made up to the 10am deadline on the day reports are due. However, it is important to allow for the fact that Turnitin only allows one submission every 24 hours. This means that trainees will need to factor this in to any plans for checking and resubmission.

Turnitin will give each report an originality score: this identifies text matches with other documents, including (for example) any quotations. There is no target score that needs to be achieved - the critical point is to ensure that ideas and quotations are properly referenced in an appropriate academic style, not to aim for a particular unoriginality score. As such trainees should use their own judgment to decide whether higher scores are legitimate (for example, because Turnitin has picked up. a properly cited quotation). In this regard trainees will find it helpful to refer to the excellent guidance on UCL's website (http://www.ucl.ac.uk/current-students/guidelines/plagiarism), which is also included as Section 23 of the Training Handbook. The Academic Manual also contains information relevant to this issue (www.ucl.ac.uk/srs/academic-manual/c4/irregularities-plagiarism/principles).

Because Moodle and Turnitin submission can be rather slow trainees should not leave submitting their work until the last minute, since this will not leave enough time to run a test submission and check for inadvertent plagiarism.

Please address any queries relating to Clinical Report submission to Sharinjeet Dhiman (s.dhiman@ucl.ac.uk).

Checking that the report has been submitted
If the report has been successfully submitted Turnitin will issue a receipt with the date and time of submission. If this receipt is not issued trainees should assume that the report has not been submitted (i.e. there has been some sort of malfunction). If attempts to resubmit are not successful the Placement Administrator should be contacted so that the course is aware of the difficulty.

Procedure for marking reports

A marking guidance document is appended to this chapter. Trainees and markers are advised to consult this document alongside the more detailed and specific guidance in handbook Chapters 21 and 25.

Clinical Reports are marked using a “sampled second-marking” system. This system is in line with UCL assessment regulations (more information available here).

Each report is marked by a single marker, who does not know the candidate’s identity. A sample of at least 10% of reports is reviewed by a moderating marker, to ensure fairness and consistency in the way marks have been applied. This sample contains:

1. All failed reports
2. A selection of examples of “typical” passes and stipulated revisions
3. A selection of “borderline” marking cases (for example, stipulated revisions that were close to being awarded a pass, or vice versa).

In any rare instances where the moderating marker considered that there is a problem with the way marks have been applied, they will liaise with the Deputy Chair of the Board of Examiners who will give direction on appropriate action to be taken. Similarly, if the moderating marker first-marks any reports and assigns them a “fail” mark, they will liaise with the Deputy Chair of the Board of Examiners to arrange moderation.

Moderating markers will not add additional comments to any reports they have reviewed, and all candidates will receive marks and feedback from their marker only.

Marking categories

The criteria for each type of clinical report are set out in the guidelines for clinical reports (see Section 21 of this handbook). There are three possible marking categories:

- Pass
- Stipulated revisions (2 months)
- Fail

The criteria for assignment to these categories are as follows:

Pass
The report meets the requirements of the particular assignment as it stands. This does not necessarily mean that it is "perfect" (although it may be). Feedback and suggestions for improvement provided by the marker is intended as learning points, and trainees are advised to take notice of these, including in preparing future reports.

Stipulated revisions
A trainee may be asked to make revisions to a report where there are issues or concerns that need to be addressed before the report can be of a passing standard. Often these will relate to the way in which the clinical presentation and/or work is conceptualised, understood and reported, or the report's fit with a particular clinical report format. As such, multiple areas of the report will likely need to be re-considered and/or re-written. Examples of stipulated revisions are included in the marking guidance document appended to this chapter.

Fail
This category is used when the report as a whole falls seriously short of expected standards. This would be the case when the clinical work being described does not meet the usual professional standards in essential ways, or when the report falls significantly below the academic standards expected of doctoral level work. Problems may include work that raises major ethical problems, a clearly inappropriate clinical approach to the work, or a confused or incoherent approach to reporting.

A failed report will be reviewed by the moderating marker, and will also go for moderation to the Chair or Deputy Chair of the Exam Board. If the fail would lead to failure of the course, then the Chair or Deputy Chair of the Exam Board may also consult with the Exam Board. All failed reports are reviewed by external examiners in the scheduled Exam Board meetings.

Feedback on the report

Feedback will be returned on a standard sheet, normally five weeks **after submission.** This will show the final mark, along with feedback from the marker.

Trainees can expect to receive reasonably detailed feedback from their marker, indicating both the strengths and limitations of their report. In circumstances where, after careful consideration, the trainee is unclear about the feedback and/or stipulated revisions, they may seek clarification from the marker. Where the trainee understands the feedback but, after careful consideration, is unsure how to make stipulated revisions, they should discuss this with their course tutor. It is the trainee's responsibility to decide how the specified changes can be made (for example, deciding which parts of the report to edit in order to accommodate additional issues raised by the marker).

There is further guidance on how feedback should be delivered in the marking guidance document appended to this chapter.

Procedures for resubmission following stipulated revisions

Where revisions to a report were stipulated, trainees should submit the revised report through Moodle. There will be a dedicated link, e.g. ‘Clinical Report 1: Stipulated Revisions’.

The submission **must** include:

- A written statement that provides a clear account of all the changes that have been made, cross-referencing the points on the marker sheet. All points on the mark sheet should be addressed. The written statement should be included at the beginning of the revised report, so that only one document is uploaded.
- The revised report, showing changes from the original in ‘track changes’, so that the marker can see where changes from the original have been made.

As above, the written statement and revised report should be uploaded as **one** document, as Moodle cannot accept multiple uploads from the same candidate.

Trainees’ original report markers will mark the resubmission. If it is judged to reach passing standard, trainees will receive a revised mark sheet showing the mark and giving any relevant feedback.

Where revisions set out in the original marking have not been satisfactorily addressed, or new concerns are raised that mean the report is not of a passing standard, the resubmitted report will be given a fail. At this point, the report will be reviewed by the moderating marker, as all reports receiving a fail require moderation. If both the original and moderating markers agree the report should fail, trainees will receive a mark sheet reflecting this and giving any relevant feedback. As noted above, a failed report will be reviewed by the Chair or Deputy Chair of the Exam Board. A new report, usually based on a different piece of clinical work, will need to be submitted. If a failed report would lead to failure of the course, then the Chair or Deputy Chair of the Exam Board may also consult with the Exam Board.

Complaints

Trainees with concerns about the procedures that have been followed in marking their report should initially raise this with their course tutor. In cases where there appears to be legitimate concern, the matter can be raised with the Chair of the Examination Board, who will consider appropriate courses of action – these might include upholding the original decision, or requesting re-marking.

It should be noted that complaints can be based solely on procedural grounds, and simply disagreeing with the decisions of the marker will not be considered. Trainees whose reports have been failed can invoke the same procedure.

If trainees are not satisfied by the outcome of this internal procedure, they can invoke the UCL student complaints procedure. This is outlined here.

SECTION 26: PROCEDURES RELATING TO PASSING AND FAILING:

THE MAJOR RESEARCH COMPONENT

Marking procedure and criteria

The thesis is expected to make a distinct contribution to the knowledge of the subject and afford evidence of originality shown by the discovery of new facts and/or the exercise of independent critical power.

It is examined by an oral examination conducted by at least two examiners, one of whom is external to the University.

The examination will be designed to test the thesis against the criteria stated above. The possible outcomes of the oral examination are:

(i) Pass
(ii) Pass conditional on minor corrections (one month)
(iii) Referred for stipulated revisions (three months)
(iv) Referred for major revisions (one year); a further oral examination, following resubmission, may be held at the discretion of the examiners
(v) Fail: no resubmission permitted

You can find detailed information about the criteria for viva outcomes in the guidelines for thesis examiners:
www.ucl.ac.uk/dclinpsy/trainee-research/Research_documents/res_evaluatethesis

Complaints

Section 30 details complaint procedures. Briefly, trainees with concerns about the procedures which have been followed in assessing their thesis should initially raise this with the Chair of the Examination Board, who will consider the complaint and the steps to be taken, usually in conjunction with the Course's head external examiner.

If trainees are not satisfied by the outcome of this internal procedure they can invoke the UCL complaints procedure.

SECTION 27: PROCEDURES RELATING TO PASSING AND FAILING PLACEMENTS

Failed placements are relatively uncommon occurrences but, as in any professional training, there will be times when a trainee is significantly underperforming and/or progress is not being made, and the possibility of placement failure arises. Although raising concerns about underperformance can be difficult for the supervisor and traumatic for the trainee, the gatekeeping role of the supervisor and the course is important. The profession has a duty of care to the general public, and it is important that we identify individuals who are not making progress on the course.

This section describes the criteria that are used to judge when a placement is failed, the procedures the Course will follow if placement failure is indicated at any stage of the placement, and the procedure for appealing should the Examination Board ratify a decision to fail a placement.

When reading what follows, it is helpful to bear in mind that:

- The criteria used to set-up, to monitor and to evaluate placements are described in Sections 7-10, and 11-16 of the Training Handbook.

- For the purposes of the Examination Board all placement activity is treated as 6-month placement periods. On this basis one-year placements are made up of two 6- month placement periods, each of which needs to be passed successfully.

- Supervisor’s judgements form a recommendation to the Board of Examiners. The Board of Examiners considers the appropriateness of the supervisor’s judgements. For this reason supervisors cannot fail a placement, but can refer the trainee to the Examination Board.

CRITERIA USED TO JUDGE THE SIGNIFICANCE OF POOR PLACEMENT PERFORMANCE

There can be a number of reasons for a trainee’s work on placement being problematic. Trainees should be reassured that the Course will take into account any factors which contribute to under-performance, and which are not directly related to clinical competence. For example, learning will be reduced if trainees are under stress (as would be the case if they are seriously ill or have suffered a major bereavement), there is only limited experience available in a placement, or supervision is problematic.

Specific difficulties on placement are not always grounds for failure. Decisions to fail placements will depend on a judgement about the gravity and significance of the difficulty, and evidence that no or little learning is taking place even when appropriate training and supervision has been given.

PART B – Overall evaluation of placement
Supervisor(s) to complete at MPR

Factors which may be relevant to judgements

Stage of training: As described more fully in Section 11, supervisors' appraisals will take into account the stage of training. The standards required of trainees will shift across the three years of the programme, and this will be reflected in the significance with which any problems are viewed. A trainee might pass an early placement because they are given the benefit of the doubt – difficulties are attributed to inexperience rather than a lack of ability. However, if the same problems recurred in later placements this might indicate that learning is not taking place, and could lead to a judgement that the required standards are not being met.

Performance in previous placements: Although judgements usually relate to performance in a particular placement, a trainee's "history" is relevant. For example, if supervisors in successive placements raised the same concern this would be relevant to judgements by the Board of Examiners about the significance of poor performance.

Opportunities available on placement: Factors relating to the service within which the placement is located may restrict or limit the experiences of the trainee, and hence their performance. The MPR visitor will need to be involved in such cases.

Wellbeing of the trainee: Extenuating circumstances (such as illness or major life-events) will make it harder for the trainee to learn while on placement. The course and the MPR visitor will need to be alerted by the trainee, as early as is possible, in such cases, especially when the impact of external events is enduring.

SIGNALLING CONCERNS ABOUT PLACEMENT PERFORMANCE

If a trainee's performance on placement raises questions about placement failure, it is important that concerns are signalled clearly both to the course and to the trainee. Supervisors can draw attention to poor performance at any stage of the placement, but the expectation is that any serious concerns would be raised at or before the MPR visit. These can then be discussed with the supervisor and trainee and specifically identified in the MPR report, along with an indication of the actions needed to rectify any problems.

Although it is desirable for concerns to be signalled by the time of the MPR (because it gives the maximum opportunity for remedial action to be taken), in some cases concerns emerge only after the MPR. Where this is the case supervisors should raise concerns with the MPR visitor and the trainee as soon as is feasible. It should not be the case that trainees only learn of a possible placement failure at the End of Placement Review.

When the possibility of placement failure is raised it is important that the supervisor and college visitor identify what changes the trainee needs to make in order to pass the placement. As far as possible this should be done by setting targets in a behaviourally-specific manner. However, it needs to be recognised that the complex skills required of trainees may not always be reducible to this level. For example, some higher-level capacities (such as evidence of an ability to reflect on their performance) may be hard to specify in anything other than a relatively abstract form.

PART B – Overall evaluation of placement
Supervisor(s) to complete at MPR

ACTION TAKEN WHEN POSSIBLE PLACEMENT FAILURE IS INDICATED

1) When concerns about possible placement failure arise (at any point in the placement), the supervisor and MPR visitor will need to complete the relevant sections on the MPR/EPR form. This includes checking the boxes relating to possible placement failure, and if those boxes are checked, the supervisor, trainee and MPR visitor **must** complete Appendix 2 of the MPR/EPR form: *Action plan for concerns regarding placement progression.*

2) A clinical viva will be required whenever the supervisor indicates that referral to the Examination Board is possible. The MPR visitor is responsible for letting the Examination Board know that a viva is indicated, at which point the Examination Board will set a date for a clinical viva. If, prior to the viva, supervisor's feedback indicates that relevant targets have been met, the Chair of the Examination Board (in consultation with the Head External Examiner) has the option of cancelling the clinical viva.

CRITERIA FOR PLACEMENT FAILURE

The criteria used for evaluating clinical competence are those contained in the MPR/EPR form. The supervisor's ratings of "PASS" or "REFER TO EXAMINATION BOARD" constitute advice to the Board of Examiners.

Placements may be judged a "FAIL" by the Board of Examiners because of serious or persistent shortcomings in any of the areas covered by the Supervisor's Feedback Form; that is, failure on the part of the trainee to reach minimally acceptable levels of clinical and/or professional competence judged in the context of the stage in training and the opportunities provided in the placement.

A placement which is failed because of a serious breach of the profession's Code of Conduct may, at the discretion of the Board of Examiners, be deemed to constitute grounds for overall failure of the Course.

A trainee may also fail a placement if insufficient clinical experience has been gained during the placement period. If this is the fault of the supervisor (e.g. due to ill health, consistent unavailability or evidence of very poor supervision) then the Course will make every effort to ensure that the trainee is not penalised and every effort will be made to provide appropriate work during the third year. Nevertheless, a delay to the completion of training may be unavoidable.

PROCEDURES FOR THE CLINICAL VIVA

Purpose
The clinical viva represents an opportunity for an independent appraisal of the trainee's clinical and professional capacities. This is because the examiners can recommend that the placement be passed if they feel that the trainee's performance at the viva addresses and assuages the concerns that have been raised.

Timing
As noted at the start of this section, for the purposes of the Examination Board all placement activity is treated as 6-month blocks. On this basis one-year placements are treated as two 6-month placement periods, each of which has to be passed.

The viva will normally be held as close to the end of the placement period as is feasible. Bearing in mind the above definition of placements:

Vivas for placements running from October-April will typically be held in late April/early May.
Vivas for placements running from April-October will typically be held in October.

Examiners
The viva will be conducted by one internal and one external examiner. Both will be members of the Examination Board, and the internal Examiner will not have acted as a Course Tutor or MPR visitor for the trainee at any stage in their training.

Content
The content of the viva will reflect the concerns raised by the placement supervisor. This means that the viva can include consideration of both clinical and professional issues. The candidate will be advised by the Chair of the Examination Board about the specific content of the viva in order to ensure that they are clear about what is required and expected.

Content where concerns primarily relate to clinical performance
The examiners will ask the trainee to present an example of their clinical work from the placement in question.

The candidate will usually be asked to submit a case that they consider to be representative of their work in the placement, and to present a detailed account of a clinical session.

Prior to the clinical viva, the placement supervisor should be asked by the trainee with support from MPR visitor as necessary to confirm in writing that the clinical work which is chosen for discussion at the viva was undertaken within the placement, and to comment on whether, in their judgment, it is representative of their usual standard of work. This agreement should then be submitted (e.g. by attaching the email chain with supervisor's confirmation) along with the recording/any other supporting documents, in line with the deadline set by the course prior to the viva (see *'Materials to be submitted'* below)

PART B – Overall evaluation of placement
Supervisor(s) to complete at MPR

Materials to be submitted

The trainee will need to submit the following materials **at least two weeks before the viva**:

1) A succinct written account of the case which outlines:

- the clinical background and relevant history
- a formulation
- an outline of the intervention to date, which includes a rationale for the work being undertaken

The aim is to ensure that the examiners understand the context of the session, both in terms of the client's background and the point in treatment at which the session occurs.

2) As described immediately below, candidates will usually present a recording of the session accompanied by a succinct written description of the aims of the specific interventions being demonstrated, specifying:

- the theoretical model which informs the interventions demonstrated in the recording
- the type of techniques being used and/or
- the clinical issues being addressed.

3) The candidate should submit two copies of an audio or video recording of the session (usually on an encrypted memory stick).

The candidate should identify a 10-15 minute segment for the examiners to focus on (though they will listen to the whole recording). The candidate should ensure that the segment is clearly identified for the examiners.

In some instances there may be good reasons why recorded material is not available. These reasons need to be presented in advance to the Chair of the Examination Board, who can permit the trainee to present a detailed written exposition of their involvement with a client (for example, presenting process notes which cover 10-15 minutes of the session). If the service context involves indirect working, the clinical material can reflect this.

The Examiners will expect that the casework selected for discussion reflects a level of challenge and complexity appropriate to the placement and to the trainee's stage of training.

The candidate may also be asked to describe other aspects of their clinical and professional work in that placement, as deemed appropriate by the examiners. The candidate's competence will be judged against the expected level of generic as well as specific skills they would be expected to have acquired at their stage of training. As above, the candidate should also submit written confirmation by the supervisor that the work is representative of their usual standard of work.

Content where concerns primarily relate to professional behaviour

Where the placement supervisor raises concerns which primarily relate to professional behaviour rather than clinical ability, the content of the viva will reflect this. Rather than presenting a case as described above, the candidate will be usually be asked to identify and to discuss the professional issues raised by the supervisor.

Structure of the viva

The Examiners will usually ask the candidate to make a brief presentation of the relevant clinical and/or professional issues at the start of the viva. They will then ask questions pertinent to the recorded and/or written materials. They may also ask questions related to clinical feedback in the placement from the end of placement or mid-placement review reports.

The candidate will also be given the opportunity to inform the examiners of any significant personal or professional issues which they feel are relevant to their placement evaluation.

Criteria for judgments

Clinical proficiency: Examiners will benchmark their decisions against the level expected of a trainee at the relevant stage of training. Guidance on the progression expected through training can be found in Section 11 of the Training Handbook.

Professional practice: Examiners will benchmark their decisions against the standards of practice embodied in relevant HCPC Standards of Conduct, Performance and Ethics and the DCP Professional Practice Guidelines.

Outcomes of the viva

As described under item 4.5 of the Course regulations (Section 22 of this handbook), there are three outcomes from the viva:

i. Assessed placement period passed
ii. Assessed placement period passed but with stipulated requirements for the demonstration of specific competencies in subsequent placements
iii. Assessed placement period failed

The Examiners will report their recommendations to the Examination Board together with an account of their observations and findings from the viva. The Examination Board comprises at least two external examiners, the Chair of the Board, the Clinical Course Director, the relevant MPR visitors and the relevant Course Tutor for the trainee(s).

Procedures for Appeal in cases where the Board reaches a decision to fail the placement are detailed below.

Consequences of placement failure

It is a course requirement (regulation 4.6) that “candidates must pass six placement periods in order to pass the Programme”. Where a placement period is failed, the Examination Board will usually allow trainees to do an additional placement period, giving them the opportunity to demonstrate competence in the areas which led to failure. However, the Examination Board will always consider both the reasons for placement failure and the prior history of placement performance when reaching its decision. On this basis, trainees may be denied the opportunity of doing an additional placement period when:

- there is good evidence (based on patterns of feedback on performance in the failed placement and in previous placements) that the trainee’s capacity to learn and to apply knowledge and skills is limited, and it is judged unlikely that further gains will be demonstrated in further placements

- the reasons for failure represent gross professional misconduct, as defined by significant deviations from relevant professional codes (including, but not restricted to, the HCPC Guidance on ethics and conduct for students, the BPS Code of Ethics and Conduct and/or DCP Professional Practice Guidelines).

In line with UCL regulations for Professional Doctorates, failure of more than one placement period will lead to failure of the Course. This means that failing two placement periods (at any point during the training) will result in failure of the Course.

Re-taking placements: When a placement period has been failed (ie category iii above), it is expected that the trainee does an additional placement period which tests similar (though not necessarily identical) clinical competences. This means that there is no necessity for a trainee failing a placement period in one speciality (for example, work with children) to undertake further work with children. However, close attention would be paid to the *type* of competencies in which failure was indicated, ensuring that the subsequent placement period offered an opportunity for the trainee’s performance to be monitored in these areas.

Placement failure in a one-year placement: One-year placements comprise two six-month placement periods, each of which must be passed. Where the placement period that has been failed is the first half of a one-year placement, it is expected that the trainee will remain in the placement. In general this gives the trainee the greatest likelihood of demonstrating an improvement in the areas of work in which they are deemed to have failed. Although a trainee’s unhappiness at a supervisor’s professional judgement is not adequate reason to vary this position, where there is evidence that the supervisor-trainee relationship is under significant strain, or that the placement experience is unsatisfactory, the Clinical Tutor Team has the discretion to recommend a change of placement.

If the trainee passes the second placement period, this will usually be considered to compensate for one placement period. Trainees will then be required to undertake and pass an additional six-month placement period in order to meet course requirements (regulation 4.6) that “candidates must pass six placement periods in order to pass the Programme”.

APPEALS AGAINST PLACEMENT FAILURE

As described above, the decision to fail a placement is only made after the following sequence of events has occurred:

a) The supervisor's feedback form indicates a decision to 'refer the trainee to the Examination Board'
b) The trainee is given a clinical viva and the examiners recommend to the Examination Board that the placement is failed
c) The Examination Board upholds the decision to fail the placement, having taken into account evidence from the MPR/EPR form and feedback from the trainee's course tutor and (if a different individual) MPR visitor.

If the Board's decision is to fail the placement, the trainee will be informed promptly. If they wish to institute an appeal they should write by writing to the Chair of the Board with details of his/her grievance, sending a copy of this letter to the Registrar.

Appeals Process
There are two stages to any appeal:

1. An 'internal' appeal, convened by the Examination Board.
2. A University appeal (convened through the Registrar's Department)

Although both appeals need to be initiated at the same time (by writing both to the Chair of the Examination Board and the Registrar), the University will not convene an appeal panel until:

a) the internal appeal panel has met and reported back to the Examination Board and to the trainee, and
b) the trainee has informed the University that they wish to challenge the outcome of the internal appeal.

Procedure for internal appeals

Composition of the panel
The panel comprises three people, assembled by the Board. Members of the panel will not normally have been involved in the original decision to fail the placement, and should include:

- a senior member of the profession (for example, a Service Head or a Psychology Advisor to a Trust), who will chair the panel;
- two external academic adjudicators, who will usually be staff members working on a Doctoral Course in Clinical Psychology or an equivalent professional training course.

Trainees will have access to an independent advisor/advocate (the trainee may use their personal advisor or may wish to choose someone else) to assist in the matter of negotiation prior to and during the Appeal process. The Course will seek the names of people willing to act in this capacity, or the trainee may seek someone independently.

Process

The Panel will endeavour to meet as quickly as possible and set as early a date for the appeal to be heard as is feasible.

The Panel will usually hear the views of the trainee and his/her advocate or advisor (if any) in confidence before hearing the views of the supervisor(s) or course tutor(s). Relevant members of the programme team (e.g. the college visitor who undertook the MPR) and the supervisor of the failed placement should also have the opportunity to present their views in confidence to the Panel.

The Appeals Panel will have access to the trainee's file and to the written feedback which has been given about the trainee's clinical competence on previous placements.

The Panel will communicate formally the outcome of its deliberations as soon as possible to the trainee and to the Chair of the Examination Board.

Procedure for complaints to the University

The panel for the University appeal is convened by the Registrar's Department, and will usually comprise a member of Registry, and senior academic staff.

Section 30 details procedures for complaints to the university. Briefly, the procedure for consideration of appeals by candidates for research degrees can be found in the UCL Academic Manual which is available at https://www.ucl.ac.uk/academic-manual/ . In particular, Chapter 5, Part B comprises the Professional Doctorate Regulations and Chapter 6, Section 10 sets out the Student Complaints Procedure.

SUPPORT FOR TRAINEES WHEN PLACEMENT FAILURE IS INDICATED

It has to be recognised that explicitly raising concerns about placement failure by scheduling a clinical viva will place some strain on the supervisor-trainee relationship. It is also the case that trainees may find it more difficult to perform when they are aware that their clinical work is being scrutinised carefully. To some degree this additional stress is inevitable.

Appealing against a decision to fail a placement will also be stressful.

In both instances the Course recognises that it has a duty of care towards the trainee, which it will attempt to meet by ensuring that:

- Trainees are encouraged to make use of an external mentor (a Personal Advisor or an individual acting in an equivalent capacity)
- Dependent on circumstance, they may be offered additional support from within the staff team (for example, if their course tutor is also their MPR visitor)
- Trainees are made aware of the Student Counselling service, and encouraged to make use of this service if this appears warranted. An indicator of need to contact the Student Counselling service would be if the trainee experienced any degree of stress in their personal or professional lives in the period leading up to a clinical viva, or in the course of pursuing an appeal against placement failure
- Trainees are reminded of their entitlements and regulations relevant to placement failure for appeals.

SECTION 28: PROCEDURE FOR THE ASSESSMENT OF FITNESS TO PRACTISE IN A PROFESSIONAL CAPACITY FOR STUDENTS ON PROFESSIONAL PROGRAMMES AT UCL

UCL FACULTIES OF BRAIN, LIFE, MEDICAL AND POPULATION HEALTH SCIENCES

PROCEDURE FOR THE ASSESSMENT OF FITNESS TO PRACTISE IN A PROFESSIONAL CAPACITY

This document sets out the procedures for assessing the fitness to practise of students undertaking a programme of study within the Faculties of Brain, Life, Medical and Population Health Sciences at UCL that is linked to professional practice, where:

a) the programme leads to the award of a qualification that entitles the student to apply for registration as a professional practitioner with a relevant registration body, or:

b) the programme leads to the award of a qualification that entitles the student to apply for registration as a professional practitioner with a relevant registration body after a successful period of pre-registration professional practice, or:

c) the programme involves training in the application of competences relevant to the practise of a profession at a post-registration level (i.e. for students already registered with a relevant registration body[1]), or:

d) the programme involves training in the application of competences relevant to the practise of a profession, where completion of the course of study is not linked to registration as a practitioner, but where students will be applying the relevant competences in a professional context

The following procedure shall provide for the arrangements for assessing any conduct, behaviour or other matters that could bear on a student's suitability for fitness to practise their profession. The kind of conduct or behaviour of relevance in this context may manifest itself in misconduct falling under UCL's Disciplinary Code and Procedure in respect of Students *(1. Disciplinary Code, Section 8., 9. and 10. refer)*[2] or it may arise in circumstances of not disclosing a disciplinary offence.[3] Students may be subject to both procedures, though not simultaneously. The University also reserves the right to transfer a case from one procedure to the other if it becomes apparent that it is more appropriate to the matter under investigation.

The following mechanisms and arrangements for the assessment of any conduct, behaviour or other matters that could bear on a student's suitability or fitness to practise their profession, and the review of individual cases where appropriate, have been written in accordance with Article 6 of the Human Rights Act, the Equality Act 2010 and the Data Protection Act 2018 and are intended to be consistent with UCL's Charter, Statutes and Regulations for Management.

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[1] it is assumed that concerns about the Fitness to Practise of students already registered with a professional body will be raised with that body directly

[2] Appendix 1 refers.

[3] Appendix 2 refers.

1. PROCEDURE FOR THE INITIATION OF AN ASSESSMENT OF THE FITNESS TO PRACTISE IN A PROFESSION

1.1 Where the conduct or behaviour of a student may be defined as misconduct under UCL's Disciplinary Code and Procedure in Respect of Students *(1. Disciplinary Code, Section 8., 9. and 10. refer),* the matter will also be considered under that Code and Procedure.

1.2 In the event that the decision against a student under UCL's Disciplinary Code and Procedure in respect of Students is that the student is in breach of the Code and Procedure, and involves a penalty short of permanent exclusion from UCL, then the matter may also be referred for consideration by the relevant programme under the following Procedure for the Assessment of the Fitness to Practise *(1.4 below refers).*

1.3 Where the conduct does not involve a disciplinary offence as defined as misconduct under UCL's Disciplinary Code and Procedure in Respect of Students, but is considered to bear on a student's suitability of fitness to practise, the matter will be considered automatically by the programme under the following Procedure for the Assessment of the Fitness to Practise. (For example, a drink-driving offence may not ordinarily be defined as misconduct under UCL's Disciplinary Code, but would normally prompt concerns relating to fitness to practise.)

1.4 Conduct, behaviour or other matters that are sufficient to signal a need to investigate a student's suitability for fitness to practise will be reported to the relevant Programme Director.

1.5 An initial investigation panel will be established comprising senior members of staff of the programme, who will consider, in accordance with established criteria[4], whether a *prima facie* case exists for the student's conduct to be the subject of further action under the Procedure for the Assessment of the Fitness to Practise in a Professional Capacity. The initial investigation panel will determine whether the case warrants referral to a Fitness to Practise Panel, or whether there is no case and the case should be dismissed. Where, subject to the advice of the panel, the Programme Director, having consulted the Director of Division may rule that a *prima facie* case does not exist, such a ruling shall not preclude any remedial actions, as are deemed necessary by the initial investigation panel.

1.6 Where the student is referred to the Fitness to Practise Panel, the initial investigation panel will consider whether the student should be suspended from study and/or practice in order to protect the public and the student and make a recommendation to the Provost accordingly.

1.7 In cases where the student's health gives rise to initial Fitness to Practise concerns, the Programme Director should investigate these through an appropriate Occupational Health assessment. Occupational Health may seek to obtain GP records/reports and reports by treating specialists, or the case may be supplemented if necessary by a psychiatric report. This pre-referral process may negate the need for referral to the Fitness to Practise Panel.

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[4] Appendix 2 refers.

1.8 Where the Programme Director considers that the conduct is a matter for referral to the UCL Fitness to Practise Panel, and has received confirmation from the Director of Division, s/he will notify the student concerned in writing that a formal representation concerning his/her conduct has been received and that the matter will be referred for consideration under the Procedure for the Assessment for Fitness to Practise. Such notification will include the particulars of the alleged conduct in question, specify how such conduct might bear on a student's suitability for fitness to practise and provide the student with an explanation of the Procedure.

1.9 All other parties involved in bringing the representation against the student under the Procedure for the Assessment of Fitness to Practise, including witnesses, will be notified at this time that the matter has been referred to the Fitness to Practise Panel and that they may be called to provide oral evidence at the Panel hearing.

2 FITNESS TO PRACTISE PANEL

2.1 The core constitution of the Fitness to Practise Panel shall be:

2.1.1 A Chair, who shall normally be a member of the UCL Faculties of Brain, Life, Medical or Population Health Sciences appointed by the UCL Council on the nomination of the Provost;

2.1.2 An academic member of staff external to UCL who is a member of a Fitness to Practise panel within their own institution

2.1.3 For programmes that confer eligibility for professional registration, a senior member of the relevant profession

2.1.4 For programmes that do not confer eligibility for professional registration, a senior member of a profession that practises the competences being trained

2.2 Core membership may be supplemented by additional members with specific knowledge or expertise including:

2.2.1 An academic member of staff from the UCL Faculty of Laws

2.2.2 The Registrar and Head of Student & Registry Services, or his/her nominee

2.2.3 A practising consultant psychiatrist**;**

2.2.4 A medical professional;

<u>Note</u>: Members of the Fitness to Practise Panel shall be asked at the time of nomination to declare any interest in or connection with the student concerned which is likely to prejudice the hearing.

2.3 The Management Lead for Fitness to Practise will normally be the Faculty Manager, Faculty of Medical Sciences, or his/her nominee, as appointed by the Vice-Provost (Health). The Secretary of the Fitness to Practise Panel will normally be a manager from the Office of the Vice-Provost (Health).

2.4 A member of the Fitness to Practise Panel required to give evidence in a case shall relinquish his/her membership of the Panel for the duration of that case.

2.5 No member of the Fitness to Practise Appeals Panel *(4.8 below refers)* shall be a member of the Fitness to Practise Panel.

2.6 The quorum for a meeting of the Fitness to Practise Panel shall be the core membership outlined in paragraph 2.1 including the Chair or Vice-Chair acting as Chair.

3 PROCEDURE FOR A MEETING OF THE FITNESS TO PRACTISE PANEL

3.1 Notice

3.1.1 The student must be given a minimum of twenty eight days' notice of the time, date and place of the hearing and of the case against him/her.

3.1.2 Notification of a referral must be made to the Chair of the Panel not less than forty two days before the date of the hearing. The notification must include the reason for referral and an outline of the case against the student, with any supporting documentary evidence relevant to the referral which is available at this stage.

3.1.3 All documentary information concerning the case against a student's fitness to practise which is submitted prior to the hearing by the relevant Programme Director, and which will be taken into consideration by the Panel during the hearing, shall be provided to the student and Panel members not less than twenty eight days before the date of the hearing. No further written evidence will be accepted unless specifically requested by the Chair of the Fitness to Practise Panel or agreed in accordance with paragraph 3.1.4. The documented case from the Programme Director should contain a detailed chronological summary of the student's file/record. The reasons for referring the student to the Panel, and the Programme Director's concerns should be clearly outlined in the Programme Director's summary.

3.1.4 The student's statement of mitigation and all supporting documentation which will be taken into consideration by the Panel during the hearing, shall be provided by the student or their representative (see paragraph 3.2.4) not less than seven days before the date of the hearing. No further written evidence will be accepted unless specifically requested by the Chair of the Fitness to Practise Panel or agreed in accordance with paragraph 3.1.4.

3.1.5 In the event of the documentation referred to at 3.1.2 and 3.1.3 above not being received within the prescribed timescale, or if further information pertinent to the case comes to light, the documentation will be considered and the hearing may still take place on the appointed day subject to the agreement of all parties.

3.1.6 The Notice of the hearing shall include a copy of this Procedure.

3.1.7 The student will be offered the opportunity for the hearing to be held in public.

3.2 Format for the Hearing

3.2.1 An appropriate UCL Officer or Officers will present the case against the student. The Officer(s) may be supported at the Hearing by an administrative assistant from the relevant programme.

3.2.2 The Chair of the Panel may invite witnesses of the alleged misconduct to attend the Fitness to Practise hearing. The student, student's representative or the UCL Officer may recommend appropriate witnesses to the Chair of the Panel. The witnesses will not normally be privy to the documentary information that is made available to the student and Panel members.

3.2.3 The Chair of the Panel may additionally invite ‘expert witnesses’ to the hearing. Expert witnesses are called to comment on the alleged unfitness to practise because of their professional knowledge or professional relationship with the student, rather than by any necessary first-hand witness of the alleged misconduct. Expert witnesses will normally be privy to the information that is made available to the student and Panel members.

3.2.4 The student is strongly encouraged to attend throughout the hearing and may enlist the help of one representative to present his/her case, The student must inform the Chair of the Fitness to Practise panel of their representative’s identity at least two weeks before the panel meets. The representative may (but need not necessarily) be a member of the legal profession. If the representative is not a member of the legal profession then s/he will normally be a member (staff or student) of UCL. If s/he is not a member of the legal profession or a member of UCL then the Chair of the Fitness to Practise Panel will decide whether the proposed friend is a suitable person to attend in that capacity.

3.2.5 The Panel shall be empowered to call any person before it to clarify evidence.

3.2.6 The student and/or his/her representative will be entitled to cross-examine those individuals referred to at 3.2.1, 3.2.2, 3.2.3 and 3.2.6 above as appropriate.

3.2.7 The proceedings of the Fitness to Practise Panel will normally be audio recorded in full except when the Panel withdraws to consider its decision.

3.3 Decisions of the Panel

3.3.1 The Panel shall deliberate in the absence of all parties.

3.3.2 The Panel will normally sit between the hours of 9.00am and 6.00pm. The Hearing will normally continue and the Panel deliberate until a decision has been reached. An adjournment may take place if a decision has not been reached.

At the conclusion of the hearing the Panel may:

3.3.3 Dismiss the complaint, or

3.3.4 Find that the student is fit to practise, but that the conduct of the student has been such as to warrant a formal warning, which will remain on the student’s file for the duration of their registration with the programme and may be taken into consideration in the event of future allegations being made about the student’s fitness to practise, or

3.3.5 Find that the student is unfit to practise. The student will not be permitted to complete the programme of study leading to the award of the relevant degree but (dependent on the regulations that apply to their programme of study) may be eligible to complete, or be awarded, an alternative degree or other qualification, subject to satisfying the necessary academic criteria and approval, or

3.3.6 Find that the student is unfit to practise but that the decision not to allow the student to complete the programme of study leading to the award of the degree may be reviewed by a Fitness to Practise Panel within a stated period of time, or

3.3.7 Make such other findings and recommend such other action as it deems appropriate in the circumstances of the case.

3.4 Decisions of the Fitness to Practise Panel, and the reasons for those decisions, made under 3.3.4, 3.3.5 and 3.3.6 above may be disclosed to the appropriate regulatory body, or other public authority based on relevant regulatory requirements. All students who have been subject to the Procedure for the Assessment of the Fitness to Practise and who have received a sanction are asked to disclose this information to the appropriate regulatory body as part of their application for provisional registration. Should a full transcript of a Hearing be required by the regulatory body or other relevant public authority, it will be made available at cost to the student. Medical students who are not permitted to complete the programme of study or be awarded the degree will be notified to the General Medical Council and Medical Schools Council for inclusion in the Excluded Student database

3.5 Findings under 3.3.4 to 3.3.7 above will include recommendations by the Panel on appropriate advice and guidance to be given to the student.

3.6 The decision of a Fitness to Practise Panel shall be reached by a majority vote of the members of the Panel, and shall be announced as the decision of the Panel. The Chair shall have a second or casting vote.

3.7 The votes of individual Panel members shall always be treated as confidential and there shall be no disclosure either of such votes or of information showing whether the decision was reached by a unanimous or a majority vote.

3.8 Upon completion of its deliberations the Panel shall notify its decision to the Vice-Provost (Health). The Vice-Provost (Health) will then notify the student, the relevant Programme Director, the Registrar and Head of Student & Registry Services and other relevant parties, in writing and with reasons, within seven days of the date of the hearing.

3.9 The written notice of the decision to the student shall include notice of the student's rights of appeal, the time within which the appeal must be made and the grounds upon which such appeal may be made.

3.10 The Chair may provide formal written feedback to the relevant Programme Director, student, or other parties, as necessary and proportionate, following the hearing. This may include any areas of concern raised by the panel about the case presented.

3.11 Where a student is permitted by the Fitness to Practise Panel to continue in practice, but new evidence emerges that indicates ongoing concern regarding their fitness to practice, then the programme may re-refer them to the Fitness to Practise panel, following the procedures set out at 1.5-1.8 above.

4 APPEALS

4.1 Notice of intention to appeal by the student against the decision of the Fitness to Practise Panel must be made in writing to the Vice Provost (Health) within twenty-eight days of the date of the notification to the student.

4.2 Such notice shall include all documentation pertaining to the grounds on which the appeal is being made. No further communications of any sort will be accepted for consideration under an appeal after this time.

4.3. Such an appeal may be made only on one or more of the following grounds:

4.3.1 That the proceedings of the Fitness to Practise Panel were not conducted in accordance with the above procedures;

4.3.2 That fresh evidence has become available which was not and could not reasonably have been made available to the Fitness to Practise Panel;

4.3.3 That the decision of the Fitness to Practise Panel was inappropriately severe.

4.4 As soon as is practicable after receipt of such notification the Vice-Provost (Health) shall appoint a Chair of the Fitness to Practise Appeals Panel and shall present the documentation relevant to the appeal to the Chair, who shall decide on the evidence available whether or not the appeal should be proceeded with. The Chair of the Fitness to Practise Appeals Panel shall be a member of the legal profession, not being a member of the UCL Council or of the UCL staff.

4.5 If it is decided not to proceed with the appeal, the Chair of the Fitness to Practise Appeals Panel shall inform the Programme Director and the appellant of the decision, giving reasons, normally within seven days of the Chair having received the documentation.

4.6 Where it is decided that the appeal shall be proceeded with, the Chair of the Fitness to Practise Appeals Panel shall inform the Registrar and Head of Student & Registry Services, who shall inform all parties of the decision of the Chair of the Fitness to Practise Appeals Panel and will make the necessary arrangements for the appeal to be held as early as possible. All parties shall be informed of the date of the appeal.

4.7 Where an appeal is granted, and the student has been allowed to remain in registration, the student shall normally be permitted to continue with his/her programme of study until the Fitness to Practise Appeals Panel has reached its decision.

4.8 A Fitness to Practise Appeals Panel shall consist of:

4.8.1 The Chair and two individuals, not being members of UCL Council or UCL staff or students, to be appointed by the Chair, as and when the Appeals Panel needs to be convened; at least one of these must be a registered member of the professional body relevant to the training programme.

4.8.2 None of the above shall have been a member of the Fitness to Practise Panel against whose decision the appeal is made, nor a member of any department involved, nor have assisted the appellant in any way with the presentation of his or her case either for the Fitness to Practise Panel or for the Fitness to Practise Appeals Panel, or the Discipline Committee if proceedings have also been initiated under the Disciplinary Code and Procedure in Respect of Students.

Note: Members of the Fitness to Practise Appeals Panel shall be asked at the time of nomination to declare any interest in or connection with the appellant which is likely to prejudice the hearing.

4.8.3 The quorum for a Fitness to Practise Appeals Panel shall be three including the Chair.

4.8.4 The secretary of the Fitness to Practise Appeals Panel shall normally be appointed from the UCL's Registry and Academic Services Division. He or she shall not have acted as secretary to the Fitness to Practise Panel.

4.8.5 The Fitness to Practise Appeals Panel and the student shall be supplied with a report of the proceedings of the Fitness to Practise Panel *(paragraphs 4.8.6-.7 below refer)* which shall be prepared by the secretary of the Fitness to Practise Panel in consultation with all relevant parties, and with such other evidence as is considered appropriate.

4.8.6 The report shall contain a statement of the matters investigated, a summary of the evidence, and the reasons for the decision reached. It should also comment on the appeal case brought by the student.

4.8.7 It shall also include, where applicable, fresh evidence which was not made available to the Panel *(4.3.2 above refers).*

4.8.8 At any Fitness to Practise Appeals Panel, the student whose case is being considered shall be entitled to be present throughout the hearing, except when the Appeals Panel considers its decision, and to present his/her case personally either alone or with the assistance of a representative of his/her choice who shall normally be the person who acted in this capacity at the Fitness to Practise Panel hearing, or, if he/she so wishes, he/she may be represented by a solicitor whom he/she may pay for his/her services. The Officer who presented the original case and the Chair of the Fitness to Practise Panel should also be present and have the right to comment on the student's submission.

4.8.9 A Fitness to Practise Appeals Panel shall have power to reverse or modify the decision appealed against in any way that it thinks fit provided that it shall not normally impose any measure which is more severe than that appealed from.

4.8.10 In reaching its decision a Fitness to Practise Appeals Panel shall take into consideration the evidence provided under 4.8.6 - 4.8.8 above.

4.8.11 The decision of a Fitness to Practise Appeals Panel shall be reached by a majority vote of the members of the Panel, and shall be announced as the decision of the Panel. The Chair shall have a second or casting vote.

4.8.12 The votes of individual Appeal Panel members shall always be treated as confidential and there shall be no disclosure either of such votes or of information showing whether the decision was reached by a unanimous or a majority vote.

4.8.13 The Secretary of the Appeals Panel shall notify the student, the Programme Director and other relevant UCL officers, within seven clear days, of the decision of the Appeals Panel, together with the reasons for the decision. A report of the proceedings shall be submitted to the Vice Provost (Health).

4.8.14 A decision of the Fitness to Practise Appeals Panel shall be final as far as UCL's internal procedures are concerned (*paragraph 4.8.15. below also refers*).

4.8.15 The written notice of the decision to the student shall include notice of the student's rights of appeal to the Office of the Independent Adjudicator, the time within which the appeal must be made and the grounds upon which such appeal may be made.

5. OFFICE OF THE INDEPENDENT ADJUDICATOR [OIA]'S STUDENT COMPLAINTS SCHEME

5.1 The Office of the Independent Adjudicator for Higher Education [OIA] has been established to provide an independent scheme for the resolution of student complaints. All Higher Education Institutions [HEIs] are required to comply with the Scheme which came into effect from 1 January 2005. Areas of complaints covered by the OIA will include:

- a programme of study or research for which the complainant was registered
- a service provided by UCL
- a final decision by a UCL disciplinary or appeal body

5.2 The OIA will not, however, advise about a complaint if:

- it relates to a matter of academic judgement (which will normally be about a student's academic performance)
- the matter is or becomes the subject of court or tribunal proceedings
- it concerns a student employment matter.

5.3 Forms and further details on the operation of the OIA are available from the OIA web site www.oiahe.org.uk including Guidelines on Fitness to Practice Procedures. Alternatively, if you wish to make a complaint to UCL, please email UCL's Casework Team on: casework@ucl.ac.uk; tel: 020 3108 8207. The UCL Rights and Advice Office (020 7679 4130, UCL ext. 34130) can provide further information.

APPENDIX 1

UCL's Disciplinary Code and Procedure in respect of Students can be found at:
http://www.ucl.ac.uk/academic-manual/part-5/disciplinary-code

APPENDIX 2

Circumstances that *prima facie* would render a student unfit to practise may include the following:

- Exploiting the vulnerability of a patient to establish a sexual relationship
- Dishonesty or fraud, including dishonesty outside the professional role;
- Offences against the vulnerable, including children, the elderly and the mentally incapacitated
- Aggressive, violent or threatening behaviour
- Criminal conviction, caution, reprimand or penalty notice of disorder (PND) or equivalent;
- Intimidation of fellow students or patients on religious, ethnic, racial or other grounds
- Repeated inappropriate behaviour
- Health concerns and lack of insight or management of these concerns including failure to seek appropriate medical treatment or other support, failure to follow medical advice or care plans, including monitoring and reviews, in relation to maintaining fitness to practise, failure to recognise limits and abilities or lack of insight into health concerns or treatment-resistant conditions that might impair fitness to practise
- Being a carrier of a serious communicable disease
- Failure of treatment for chronic mental health
- Chronic drug or alcohol abuse
- Unprofessional behaviour or attitudes including breach of confidentiality, sexual, racial or other forms of harassment, failure to observe appropriate boundaries in behaviour, persistent rudeness, bullying; unlawful discrimination;
- A failure to abide by professional codes of conduct that apply to the profession being trained by the programme.
- Persistent inappropriate attitude or behaviour including lack of commitment to academic work, neglect of administrative tasks, poor time management, infrequent or non-attendance, poor communication, failure to accept or follow educational advice, failure to follow health and safety requirements, or failure to follow the rules and regulations of the programme.

Version	**Date**	**Amendments**	**By**
1	05/03/2013	Regulations agreed and approved	SLMS Education Board
2	30/5/14	To update section 2.3 in respect of the new admin structure	SEG
3	07/09/21	To update section 3.1.2 in respect of the submission of outline documentation to the Chair	Vice Provost (Health)
4	07/09/21	To remove reference to the School of Life and Medical Sciences	Vice Provost (Health)
5	07/09/21	To clarify that recommendations for suspension of study are referred to the Provost	Vice Provost (Health)
6	07/09/21	To include referral to the GMC and Medical Schools Council of students who are not permitted to continue	Vice Provost (Health)

SECTION 29: FITNESS TO PRACTISE

A guide for students on professional programmes in the UCL School of Life and Medical Sciences (SLMS)

Background

Students on professional training programmes in SLMS are expected to conduct themselves and to behave in a professional manner at all times, both at UCL, in the workplace and in their conduct outside of work, in line with the professional codes of practice that apply to their discipline. Professional programmes have a duty to the public to ensure that students seeking to enrol and students who are enrolled meet the relevant standards of professional conduct.

Fitness to practise – the responsibilities of students and of programmes

This document focuses on the ways a programme will respond when a student's fitness to practise is called into question. However, it is critical to emphasise that all programmes would prefer to resolve issues at a stage where they can still be managed, and before they become a matter for more formal investigation. For this to happen students need to feel able to come forward and discuss problems or issues with those members of staff charged with their support. In turn, the first response of programmes will usually be to discuss the matters the student is raising and see if they can be resolved with appropriate management and support.

Although it is understandable that students will feel worried about the consequences of drawing attention to their fitness to practise, a willingness to recognise and to try to resolve concerns is an important marker that will usually count for, rather than against, the student.

Programmes to whom this document applies

The procedures outlined below apply to students enrolled on non-medical professional programmes in the UCL School of Life and Medical Sciences (SLMS) – specifically:

Doctorate in Clinical Psychology
Doctorate in Educational Psychology
Doctorate in Clinical Communication Science
BSc Speech Sciences
MSc Speech and Language Sciences
MSc Developmental Psychology and Clinical Practice
School of Pharmacy
Programmes at the Eastman Dental Institute
Post Graduate Diploma in Low Intensity Cognitive Behavioural Interventions

The procedure for the "assessment of fitness to practise in a professional capacity" is available to students at https://www.ucl.ac.uk/slms/education/ftp-procedure

Matters giving rise to concern

Students on professional programmes will be advised about the professional standards expected of them. Common examples of issues which may give rise to concern about a student's fitness to practise include (without limitation):

a) Criminal conviction, caution, reprimand or penalty notice of disorder (PND) or equivalent;
b) Aggressive, violent or threatening behaviour;
c) Cheating or plagiarising;
d) Dishonesty or fraud, including dishonesty outside the professional role;
e) Persistent inappropriate attitudes or behaviour including:
    lack of commitment to academic work;
    neglect of administrative tasks;
    poor time management;
    infrequent or non-attendance;
    poor communication;
    failure to accept or follow educational advice;
    failure to follow health and safety requirements;
    failure to follow the rules and regulations of the university and/or the programme
f) Unprofessional behaviour or attitudes including:
    exploiting the vulnerability of a client to establish a sexual relationship;
    failure to observe appropriate boundaries in behaviour;
    offences against the vulnerable, including children, the elderly and the mentally incapacitated;
    breaches of confidentiality;
    sexual, racial or other forms of harassment;
    persistent rudeness, bullying;
    unlawful discrimination
g) Disciplinary offences within the programme;
h) Health concerns and particularly a lack of insight or management of these concerns, including:
    failure to seek appropriate medical treatment or other support;
    failure to follow medical advice or care plans, including monitoring and reviews, in relation to maintaining fitness to practise;
    failure to recognise limits and abilities or lack of insight into health concerns and/or treatment-resistant conditions, which might impair fitness to practise;
    failure of treatment for a chronic and serious mental health condition;
    chronic drug or alcohol abuse
i) A failure to abide by professional codes of conduct that apply to the profession being trained by the programme

An impairment or health condition may make it impossible for a student to graduate with a professionally approved/ accredited degree, preventing them from entering training, or registering with the relevant professional body. On this basis it is important that matters affecting a student's fitness to practise are managed as soon as practicable after they have arisen.

Fitness to practise prior to admission

Prior to admission onto a programme all students are required to complete a self-declaration form to inform the programme of any ongoing health concerns, previous criminal convictions or cautions, or sanctions they have received from any professional bodies, in particular healthcare regulators. Students must advise the programme of any convictions, cautions, warnings or reprimands irrespective of the reasons.

Any issues or concerns identified from the self-declaration forms will be investigated by the programme to determine whether it is appropriate or even possible for that student to be enrolled on the course.

Where information comes to light prior to the commencement of the programme that was not included on self-declaration forms, the programme reserves the right to immediately withdraw the offer of a place on the programme to the individual concerned and to notify the relevant professional body of the incident.

Fitness to practise following admission

Individual programmes may vary in their specific requirements (and will advise students accordingly), though where students are working with the public they will usually be required to undergo enhanced clearance with the Disclosure and Barring Service (DBS) and an occupational health check, usually before registration with the programme. Students may also be required to sign documentation agreeing to abide by any applicable professional codes of conduct during enrolment.

Students are expected to notify their programme as soon as is reasonably practicable if there is any subsequent change to their DBS or health status.

At the beginning of each academic year students may be required to complete a self-declaration form to certify that there has been no change in their DBS or health status.

Students are strongly encouraged to seek support for any matter before it becomes a fitness to practise concern. The student should seek advice from programme staff charged with offering student support, who can then provide appropriate and ongoing support to the student.

Health

In most cases health conditions (including disabilities) will not raise fitness to practise concerns, provided the student receives the appropriate care and reasonable adjustments necessary to study and work safely. However, certain health conditions may make it impossible for a student to graduate with a professionally approved/accredited degree.

Health issues identified during the self-declaration process and/or occupational health checks will be assessed independently by the occupational health services linked to the programme. Information confirming health clearance or advising of concerns will be notified to the programme and referrals to appropriate specialist services may be agreed in consultation with the student, particularly in relation to potential disabilities, so that appropriate adjustments can be identified and supports established as early as possible in line with the Equality Act 2010

Students may be re-referred to the occupational health service at any point during their studies. This may be due, for example, to a period of extended sick leave, the development of a new health condition or to re-assess health needs prior to the beginning of a practicum assignment/ practice placement.

A student's refusal to submit to a medical examination (for example when the student is suffering from a continuing or episodic condition or a condition in remission which may be expected to recur) may in itself give rise to a concern of an impairment to the student's fitness to practise and may be dealt with using the fitness to practise procedures.

The School encourages students to register with a local GP (and other healthcare professionals as appropriate) who will be able to offer them support and continuity of care.

Discipline
It is possible that issues which give rise to concerns about a student's fitness to practise may be based on incidents which could also constitute disciplinary offences under the UCL Disciplinary Code (www.ucl.ac.uk/academic-manual/part-5/disciplinary-code).

Programmes will investigate and address cases involving a potential overlap between disciplinary offences and fitness to practise concerns using either the student disciplinary procedure or the fitness to practise procedure. This includes the right to switch procedures if it becomes apparent during the operation of one procedure that it would be more appropriate for the matter to be addressed using the other procedure, or to run the procedures in parallel. For example during a fitness to practise investigation it might become apparent that the alleged behaviour of a student is sufficiently serious to warrant permanent exclusion from the university. At this point the case could be referred to the disciplinary procedure.

Criminal conduct
An allegation of criminal conduct will normally be reported to the police and further action under the fitness to practise procedure or the student disciplinary procedure will normally be suspended until the outcome of criminal investigations and/or subsequent criminal proceedings is known.

Initial (investigatory) stage of the fitness to practise procedure
Any person who has concerns about a student’s fitness to practise may refer the matter to the relevant programme director(s) for consideration under this procedure. The programme director(s) (along with other members of the programme team he or she nominates to do so) will conduct an initial investigation of the concerns to decide whether there is a case to answer.

The initial investigation will be proportionate and will consider the interests of clients and the public against those of the student. Where the investigator considers the concerns may have substance he or she will arrange to meet with the student to raise and discuss the concerns in order to ascertain the student’s views and/or explanation. The investigator will consider any mitigating factors as part of this initial investigation.

If concerns are substantiated, the programme director(s) (or their nominee) will determine whether referral to the formal stage of the fitness to practise procedure is appropriate.

Formal stage of the fitness to practise procedure
When concerns have not been allayed or resolved during the informal stage of this fitness to practise procedure or the concerns have been referred straight to this formal stage, the programme will notify the student in writing that the case is to be referred to a fitness to practise panel for consideration. The procedures to be followed by this panel are described in “procedure for the assessment of fitness to practise in a professional capacity” (https://www.ucl.ac.uk/slms/education/ftp-procedure)

Suspension of studies during the investigation of concerns
The fitness to practise procedure is designed to investigate whether or not there is a concern that requires a response. On this basis it will not usually be appropriate to suspend a student before these procedures have been completed (because to do so could be seen as pre-judging the issue). However, there may be circumstances where the concerns being investigated are considered serious enough to warrant immediate suspension of the student (for example, where the student’s behaviour represented a clear threat to the well-being of others, or was sufficiently concerning to raise significant concerns about the programme’s duty of care to the public).

Confidentiality and Disclosure

Disclosure to the relevant professional/ regulatory body will only take place if it is necessary and proportionate in the circumstances of the case, having considered the risks associated with not disclosing the information.

The student also has responsibility to disclose information regarding concerns about fitness to practise to the relevant registration/ professional body when applying for registration. This will be made clear to students in the letter sent to them after the Panel hearing.

The retention of fitness to practise information and the confidentiality of records relating to fitness to practise hearings will be managed in accordance with the Data Protection Act 1998.

Notice and grounds of Appeal

The grounds and procedures for appeal are outlined in the “procedure for the assessment of fitness to practise in a professional capacity” (https://www.ucl.ac.uk/slms/education/ftp-procedure).

An outline of Fitness to Practise (FtP) procedures

Procedures internal to the programme	**Stage 1** – Potential concerns come to the attention of a programme Concerns usually come to the notice of the student's tutor initially. Where possible these are responded to by the programme; where possible programmes will support the student's progression: • through the usual mechanisms for student support • by referral for appropriate external support • by referral to Occupational Health **Stage 2** – Tutor remains concerned, or the nature of the concern is such that internal support is inappropriate. The programme director is alerted and initiates the initial (investigatory) phase of the FtP procedure. The programme director and designated colleagues will investigate the matter and use the evidence available to them to consider whether the student's conduct amounts to a concern under the Disciplinary Code or FtP procedures, or both: • If it does not meet the criteria for either the matter is managed internally by the programme. • If it falls under the Disciplinary Code the student will be referred to Dean of Students (Welfare). • If it falls under FtP the student will be referred to the FtP panel and the Dean of Students (Welfare) will also be notified.
External to the programme	**Stage 3** – FtP panel meets. As an independent body this hears (and draws on) evidence from the programme and from the student and their representatives. Decisions (and recommendations) of the panel are communicated to both the programme and the student. **Appeals** The student can appeal the decision of the panel on procedural grounds, or in the basis of further information that was not considered by the panel.

SECTION 30: COMPLAINTS IN RELATION TO COURSE PROCEDURE & COMPLAINTS IN RELATION TO BULLYING, DISCRIMINATION OR HARASSMENT

Background

There are a number of procedures open to trainees who have serious concerns about their training and who wish to raise these with the Course or the University. Before detailing them it is worth observing that all these procedures encourage trainees to initiate "informal" discussion before invoking formal procedures. This is not a way of discouraging them from drawing attention to concerns, more a hope that matters can be resolved efficiently through this route. However, if this option is not felt to be appropriate by the trainee, or they feel that the outcome of 'informal' discussions has not been satisfactory, they may wish to invoke formal procedures.

In the first instance "informal" discussion means drawing attention to any concerns by talking to Course Tutors, members of staff with whom the trainee feels comfortable (for example, if the trainee feels that their relationship with the Tutor is not a good one), or with the Course Directors. The Course aims to be responsive, and many matters can be resolved through these routes. However, there may be times when the course itself is the problem, and trainees might consider a more formal procedure more appropriate. These are outlined below, with hyperlinks to the fuller descriptions available on the UCL website.

Complaints in relation to course procedures

The usual reason for initiating a complaint is that the trainee believes some aspect of course procedure or regulation has not been followed appropriately, and they wish to challenge decisions made by markers, examiners or placement supervisors.

The complaints procedures related to course assessments are the same in relation to exams, research and case reports, but there is some variation in relation to placements (see below). The relevant Sections of this handbook which focus on 'passing and failing' should be consulted for more detailed information.

The UCL Student Complaints Procedure is available at:

https://www.ucl.ac.uk/academic-manual/chapters/chapter-6-student-casework-framework/section-10-ucl-student-complaints-procedure

If after bringing any concerns to the attention of the course a resolution is not found, trainees may lodge a formal complaint to the University. Prior to initiating this, trainees should initially speak with UCL's Student Mediator (see https://www.ucl.ac.uk/student-mediator)

Complaints in relation to bullying/harassment or discrimination at UCL
Some complaints are based not on concerns about academic procedures or course delivery, but on issues where the trainee believes that they have been subject to inappropriate behaviour, such as harassment or bullying. This includes sexual and racial harassment.

As a student of UCL and as an employee (or honorary employee) of the NHS trainees should be aware of the equality and diversity policies that apply both in college and while on placement. A first – and obvious – step in making these meaningful is to ensure that trainees know that such policies exist and to whom they apply, and also know how to access them.

Equality, Diversity and Inclusion
UCL has numerous policies and procedures and sources of support covering race, gender, transitioning gender, religion and belief, LGBTQ+, and disability. The following webpage has a link to some relevant policies:
https://www.ucl.ac.uk/students/policies/equality

Further detailed information can be found on the Equality, Diversity and Inclusion website: https://www.ucl.ac.uk/human-resources/equality-diversity-inclusion

Dignity at UCL
The following website has information on UCL's policy and procedure relating to harassment, intimidation and bullying, as well as advice for staff and students:
https://www.ucl.ac.uk/equality-diversity-inclusion/dignity-ucl

You also have the option to make an anonymous report about any harassment or bullying through Report and Support. Alternatively, if you provide your name and contact details, a Dignity Advisor will then follow up with you. UCL has a network of trained Dignity Advisors who provide an informal, confidential information service to staff and students on issues relating to bullying, harassment, and sexual misconduct.

You can also make a formal complaint (if appropriate) through UCL complaint procedures. We would also encourage you to discuss any issues with course staff, so that we can support you and also investigate the issue, as appropriate.

Complaints related to clinical placements

Trainees spend a significant proportion of time in clinical settings, meaning that some complaints could arise from placement rather than college experience.

Managing minor and serious placement concerns
The Three North Thames courses have an agreed procedure for managing minor and serious placement concerns and the relevant document is available here:
https://www.ucl.ac.uk/clinical-psychology-doctorate/placement-quality-management-and-managing-placement-concerns

Complaints about placement colleagues

Complaints which arise from the behaviour of NHS colleagues with whom the trainee has contact may ultimately need to be addressed through the relevant Trust and its local investigatory and disciplinary procedures. Where a placement is not in an NHS setting, the usual course of action will be to follow the investigatory and disciplinary procedures of the placement organisation, bearing in mind C&I's obligations to the trainee and UCL's duty of care to the trainee.

Supervisors and the Course will offer support to trainees who wish to activate these procedures. The first stage would be 'informal' discussion with supervisors, Course Tutors or college visitors (as appropriate) in order to consider the best course of action, with formal complaint procedures subsequently being invoked if these are deemed appropriate.

Formal procedures may include:

- making a formal complaint (if appropriate) via local trust procedures.
- 'whistleblowing' (see C&I guidance for when whistleblowing is a potential course of action)

Complaints which relate to bullying, discrimination or harassment on placement

A specific 'class' of complaint relates to the experience of bullying, discrimination or harassment. Whether at college or on placement trainees are entitled to be treated in a manner which does not conflict with policies developed to protect the rights of each individual, usually in line with relevant national legislation.

All NHS Trusts have similar policies and procedures in relation to bullying, discrimination or harassment, and although trainees are referred to the documentation prepared by their employing Trust (Camden and Islington Foundation Trust), it is safe to assume that similar policies and procedures apply across all London Trusts. For placements outside of the NHS, the usual course of action will be to follow the relevant policy and procedure of the placement organisation, bearing in mind UCL's duty of care to the trainee. Where a smaller third sector placement provider does not have a respective policy, the principles outlined in the C&I policy should be followed.

Camden and Islington Foundation Trust Bullying and Discrimination Policy and Procedure

For ease of reference, the C&I Bullying and Discrimination Policy and Procedure (August, 2019), which covers bullying, discrimination, harassment and victimization, is in Appendix 1 to this section of the handbook. (This document is current as at 06.08.21 but trainees should check it remains the applicable policy and procedure given it is updated from time to time.)

Camden and Islington Foundation Trust Grievance Policy and Procedures (March 2019)

Grievances are concerns, problems or complaints relating to your employment that you wish to raise with management. For ease of reference, the C&I Grievance Policy and Procedures (March, 2019) is in Appendix 2 to this section of the handbook. (This document is current as at 06.08.21 but trainees should check these are the applicable policy and procedures given the document is updated from time to time.)

SECTION 31: EQUALITY, DIVERSITY AND INCLUSION POLICIES AT UCL AND IN THE NHS

As a student of UCL and as an employee of the NHS trainees should be aware of the equality, diversity and inclusion policies that apply both in college and while on placement.

A separate section of this handbook ("Complaints in relation to course procedure and in relation to bullying, discrimination or harassment") details procedures to be followed should trainees feel that appropriate policies have not been followed either within UCL or while working in the NHS or on a placement outside of the NHS, and sets out the procedures for initiating complaints in relation to bullying, discrimination or harassment.

Equality, Diversity and Inclusion at UCL
UCL has numerous policies and procedures and sources of support covering race, gender, transitioning gender, religion and belief, LGBTQ+, and disability. The following webpage has a link to some relevant policies:
https://www.ucl.ac.uk/students/policies/equality

Further detailed information can be found on the Equality, Diversity and Inclusion website: https://www.ucl.ac.uk/human-resources/equality-diversity-inclusion

Dignity at UCL
The following website has information on UCL's policy and procedure relating to harassment, intimidation and bullying, as well as advice for staff and students:
https://www.ucl.ac.uk/equality-diversity-inclusion/dignity-ucl

UCL has a network of trained Dignity Advisors who provide an informal, confidential information service to staff and students on issues relating to bullying, harassment, and sexual misconduct: https://www.ucl.ac.uk/equality-diversity-inclusion/dignity-ucl/dignity-advisors

Camden and Islington Foundation Trust Bullying and Discrimination Policy and Procedure
All NHS Trusts have similar policies and procedures in relation to bullying, discrimination or harassment, and although trainees are referred to the documentation prepared by their employing Trust (Camden and Islington Foundation Trust), it is safe to assume that similar policies and procedures apply across all London Trusts. Placements outside of the NHS will have their own policy and procedure, and the usual course of action will be to follow the relevant policy and procedure of the placement organisation, bearing in mind C&I's obligations to the trainee and UCL's duty of care to the trainee.

The C&I Bullying and Discrimination Policy and Procedure (August, 2019), which covers bullying, discrimination, harassment and victimization, is in Appendix 2 to Section 30 of the handbook. (This document is current as at 06.08.21 but trainees should check it remains the applicable policy and procedure given it is updated from time to time.)

SECTION 32: SOUCES OF PERSONAL AND PROFESSIONAL SUPPORT

While training is usually an exciting and stimulating experience, it can also be challenging and sometimes stressful. It is common for trainees to go through periods when they feel overwhelmed or upset. Making a judgment about when to seek support is not always easy; especially because these periods of stress can be fairly transient, and in some ways learning to manage them is part of the learning process. Equally, mental health professionals can be reluctant to seek help because they somehow feel that they should be able to cope by themselves, even when they know that they are finding this a challenge.

Deciding when a problem needs to be addressed is not easy, but the Course aims to ensure that trainees can seek advice and support in a reasonably timely manner. We also hope that the ethos of the Course counters any sense of stigma attached to mental health problems in trainees or in staff – after all, if we are true to the values of our own profession we should accept our own potential vulnerability, and be open to taking appropriate steps when we know that we are not managing as well as we might.

This section includes information about:
a) Trainee Wellbeing and Supporting and Valuing Lived Experience of Mental Health Difficulties in Training
b) Support systems offered by the Course (including the Personal Advisor Schemes)
c) Support systems offered by UCL, and
d) Support systems offered by external organisations

TRAINEE WELLBEING AND SUPPORTING AND VALUING LIVED EXPERIENCE OF MENTAL HEALTH DIFFICULTIES IN TRAINING

Developing skills in self-care and wellbeing are an important competence for all trainees. We want to draw your attention to the 2020 BPS/DCP guidance ‘Supporting and valuing lived experience of mental health difficulties in clinical psychology training’ which is the Appendix to this section of the Handbook. We encourage you to read through this guidance which has the following key aims/principles:

- Guidance for the training community to increase the likelihood that trainees with mental health difficulties will be supported
- Recognition that mental health difficulties are common among mental health professionals and those in training
- Challenge silence, stigma and shame
- Create a culture of compassion and openness
- Normalizing and valuing stance
- Knowing when to ask for help and doing so is a sign of professional competence
- Provide good practice examples and information about multiple sources of support for trainees and trainers

Placement supervisors also receive this 2020 BPS/DCP guidance with placement letters. An important part of the supervisory relationship is ensuring that self-care and wellbeing are discussed within supervision. The BPS accreditation standards state that individual supervision should provide “opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as ongoing case work.” The standards also state that “Supervisors should be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work.”

SUPPORT SYSTEMS WITHIN THE COURSE

Course Tutor

Each trainee is assigned a Course Tutor. The tutor's role is holistic – not only to support and advise on academic and clinical matters, but also to monitor and support personal/professional development.

The Course is keen that trainees maintain regular contact with their tutor, and that they see their relationship with the tutor as supportive. For this reason there are timetabled 'tutor slots' throughout the year which ensure that trainees meet with their tutor on a regular basis. The content of these meetings varies according to need, but usually includes discussion of academic progress and forthcoming work, experience of clinical placements and supervision, progress with research, and issues related to personal/professional development. Our intent is that the relationship between tutor and trainee is such that these meetings can also include discussion of any personal matters that are impacting on the trainee's experience of the course.

In addition to timetabled tutor slots, there is more formal discussion of progress and development at the 'developmental review', which takes place annually.

Trainees are free to contact their Course Tutor at any time, especially if there are any pressing matters that are causing concern. Access is not restricted to timetabled slots.

Mid Placement Review (MPR) visitor

Each trainee is assigned an MPR placement visitor who visits their placement and undertakes the Mid Placement Review. Often - but not always – the MPR visitor is the trainee's course tutor.

The role of the MPR visitor is to review progress in the placement and trainee development within it, and to help supervisors and trainees problem-solve if any there are any difficulties with the placement. More details of the MPR process can be found in the Section 13 of this handbook.

Research Co-ordinators

Each year group has a Research Co-ordinator who assists trainees in choosing the area for the Major Research Project, finding a supervisor, and so on (more details can be found in Section 19 of this handbook which gives details of the Major Research Project).

PERSONAL ADVISOR SCHEMES

Background

The primary role of the advisor is to provide a stable and continuous external professional focus for the trainee throughout the three years of training. Hopefully advisors will help support their trainee's professional development by acting as an independent 'sounding board', offering a regular opportunity to discuss and review their experiences on the course and to place these into a broader perspective. The advisor will develop knowledge and understanding of the trainee's background, ongoing experience of the course, and aspirations for the future. They also offer more general support, and (if the trainee wishes) can act an advocate, supporting the trainee in managing problems which arise in relation to academic or clinical aspects of the course. However, meetings are not 'therapy' and advisors are not therapists; although it is very likely that personal issues will be discussed in meetings, the emphasis should be on professional matters.

Procedure

Trainees are invited to look through the list of current Personal Advisors (held by Fran Brady, Senior Clinical Tutor) to select someone that they think might be a good fit. We recommend that trainees make contact with a personal advisor to arrange an initial meeting to discuss the IPA process and what they hope to get from their contact. It can be useful to discuss mutual conceptions of the personal advisor relationship at the outset, how the trainee would like to use the contact and where boundaries will be drawn. If, following this meeting, both the trainee and personal advisor agree that it is a good arrangement and agree to continue meeting, the trainee should inform the IPA list holder to update the folder.

The plan is for meetings to continue throughout training. How frequently visits take place is for the trainee and advisor to decide, though for the contact to be meaningful at least two visits a year seems sensible.

Meetings are confidential; the advisor will not be involved at any stage in the trainee's supervision, and there is no direct feedback between advisors and the Course. If an advisor acted as an advocate for the trainee, this would only take place at the trainee’s request.

Practical Arrangements

The timing and venue for meetings are left to the trainee and advisor to negotiate. For convenience, some pairs have met at the advisor's home, while others meet in the workplace. Meetings may be from 1-2 hours duration. Trainees are entitled to take time from their placements or study time to meet with their personal advisors.

It can be useful to discuss mutual conceptions of the personal advisor relationship at the outset, how the trainee would like to use the contact and where boundaries will be drawn.

Additional Sources of Support

LGBT and black and ethnic minority trainees

We value diversity within our trainee cohort, but we recognise that sometimes ‘difference’ can be an important issue during training, and can impact on the training experience. This isn’t inevitable, but we think it is better to recognise the possibility that some trainees might want support around this (and to offer this) rather than to deny this possibility and offer nothing.

The IPA scheme is a possible resource for trainees who may wish to address particular issues relating to parenting/caring responsibilities, sexuality or to ethnicity in relation to their training. **All personal advisors indicate on their resume whether they have a particular interest and/or competences to act as an advisor in each of these areas**.

The scheme aims to offer a private space to reflect on any issues relating to sexuality or ethnicity which may be impacting on trainees. Although trainees may want to discuss issues of concern, it would be a shame if advisors were purely seen in a ‘troubleshooting’ role. Trainees should also feel free to use the experience and expertise of advisors more widely to help with personal and professional development. The role of personal advisors is to offer support, advice and advocacy as appropriate; not to provide personal therapy.

Useful areas of discussion might include:

- Negotiating the overlap between personal and professional lives
- Feeling unique within a training peer group and making decisions about how much or how little to say about one’s sexuality or ethnicity
- Feelings of isolation within peer group, placement setting and the profession of clinical psychology
- The impact of working with clients and staff within a predominantly white or European culture, or a culture of assumed heterosexuality
- Working in systems and with colleagues who may have conflicting personal values and theoretical frameworks for thinking about ethnicity or homosexuality
- The importance of hearing the experiences of qualified clinical psychologists who come from black and ethnic minority backgrounds, or are lesbian, gay and bisexual

Parents and carers support scheme

Trainees who are parents or carers may experience training rather differently from their peers, particularly because it can be hard to balance the demands of training with the demands of these roles. For this reason it is helpful for trainees to have access to a forum for sharing experiences.

A number of personal advisors have indicated an interest and willingness to make themselves available for parent/carer trainees who may wish to discuss the sort of issues noted above. Trainees are encouraged to contact specific advisors if they think that this would be helpful.

If you have any queries about support for trainees, either talk to your course tutor or to Fran Brady (Senior Clinical Tutor).

Policy for the IPA system

a) The scheme should operate in a way that ensures continuity, confidentiality and impartiality.

b) The personal advisor for any particular trainee will not act as a clinical supervisor to that trainee at any time.

c) Advisors should meet at least two times per year. Regular contact should be scheduled, rather than waiting for problems to arise.

d) The clinical trainee may additionally request to see their advisor at any time, and advisors should attempt to respond to such a request within a short period of time.

e) Contact between the advisor and the trainee will remain entirely confidential, including details of the time and content of meetings.

f) Trainees or advisors who consider that the pairing is unsatisfactory and wish to change should approach the co-ordinator of the scheme. The trainee will be assigned a new advisor.

g) Where an issue appears to have reached an impasse, and all attempts to settle the matter directly with the trainee have failed, clinical and academic supervisors may approach a trainee's advisor in order to request or prompt some help in mediating the problem. Such an approach can only be made on the understanding that the advisor acts primarily as an advocate for the trainee, and can only be involved with the trainee's consent.

Involving the advisor in appeals and disputes

Where a trainee feels that he/she has been dealt with unfairly by the course in any respect, the trainee may request that the advisor becomes involved as an advocate.

This policy is not intended to replace, or in any way alter, any policies currently operated in University College London, or in specific Health Authorities, regarding disciplinary or appeals procedures. Disputes will normally be dealt with in the first instance by the trainee directly. The advisor will only become involved at the trainee's request and after appropriate attempts by the trainee to resolve the problem.

Student Psychological Services

The service offers a range of interventions, including brief CBT. Recognising the fact that trainees are full-time employees the service tries to be flexible when offering appointments (for example, by scheduling these early in the day or in the evening).

Details of the service can be found at http://www.ucl.ac.uk/student-psychological-services/index_home

Online support

There is an online mutual support group for UCL students at www.ucl.ac.uk/support-pages

Support for trainees with disabilities and/or special needs
UCL and Departmental policy is to offer appropriate support to trainees who have disabilities or special needs. This usually means finding the best way to adapt working conditions or the working environment to meet the trainee's needs.

The term 'special needs' covers a wide range of difficulties – for example, those which relate to academic work (such as dyslexia), or disabilities which restrict travel, or which make it important that placements include appropriate access and working conditions. Trainees should feel free to discuss any special needs with Course Tutors early in the course so that (where applicable) special provision can be considered and arranged.

UCL Disability Services offers a range of services – more information can be found at: www.ucl.ac.uk/disability

Careers information and guidance
Careers advice is given throughout the course. Each trainee follows a mix of compulsory and elective placements, and their 'training plan' will usually relate to their plans for post-qualification employment. Emerging ideas about employment are usually discussed with the Course Tutor (and especially at development reviews). In the third year there is one session of formal teaching, which covers the process of applying for jobs (making applications, writing CV's and interviewing technique).

Because there is such a close link between training and employment most careers advice is given on an individual basis by Course Tutors. However, trainees can make use of facilities offered by the Career Advisory Service (www.ucl.ac.uk/careers).

Graduate School
Details of support offered by the Graduate School (including Faculty Office, Dean of Students, and Advisors to Women) can be found on the website:
http://www.ucl.ac.uk/prospective-students/graduate-study

Seeking psychological therapy and psychiatric support while on the Course

There are two common reasons for seeking therapy while on the Course:

> a) Some trainees feel personal therapy would help them to understand themselves better, and hence be more effective as psychologists. Their aim is not to resolve specific problems or symptoms but to have the opportunity to reflect at a more general level.
>
> b) Some trainees experience psychological difficulties, which interfere with their personal or professional functioning. For these individuals the motivation for seeking therapy (alone or in conjunction with more medically based interventions) is because their problems are affecting their personal and professional lives in a significant manner.

Whatever the motivation for therapy, the Course will try to help put trainees in touch with relevant individuals or organisations.

Trainees who are experiencing a mental health problem, which affects their capacity to undertake the course, and especially their capacity to undertake clinical work, are strongly encouraged to talk to a member of the Course team - hopefully their Course Tutor. Although we understand the reluctance of trainees to reveal problems to members of the Course, we can use our professional contacts to try to locate the most appropriate therapist - not always an easy task for individual trainees, especially if they are already feeling distressed.

Sometimes trainees might be best served by a standard NHS mental health referral through their GP. This will certainly be the case if their problem is more appropriately addressed by a combination of psychological therapy and medication, or by medication alone.

Potential sources of therapy for trainees

Psychodynamic therapies

The British Psychoanalytic Council (BPC) maintains a register of accredited psychoanalytic and psychodynamic psychotherapists, psychoanalysts, Jungian analysts and DIT practitioners:
www.bpc.org.uk/

The following organisations also offer consultations and different kinds of psychodynamic therapies:

1. The British Psychotherapy Foundation: www.britishpsychotherapyfoundation.org.uk

   Also offers low fee intensive psychotherapy, psychoanalysis or Jungian analysis to those who are on low incomes. There tend to be a limited number of places available: www.britishpsychotherapyfoundation.org.uk/therapy/low-fee-intensive-therapy

2. WPF Therapy: www.wpf.org.uk. Offers low cost/sliding scale time-limited and long-term psychodynamic psychotherapy and group therapy.
3. Camden Psychotherapy Unit: www.cpu-london.com/. Offers low fee (or free) short-term and long-term psychodynamic psychotherapy and group therapy.

4. The London Clinic of the Institute of Psychoanalysis: www.psychoanalysis.org.uk/iopa-clinics/low-fee-scheme. Following a consultation, offers a low-fee, five times weekly psychoanalysis for a minimum of two years.

5. The Society of Analytical Psychology: www.thesap.org.uk/therapy-services/consultation-service/. Offers consultations for Jungian psychotherapy and analysis.

6. The Institute of Group Analysis: www.groupanalysis.org. Specialises in group therapy but can also offer individual, couple and family therapy. Offers an informal telephone discussion and will then put you in touch with a therapist for an initial consultation.

CBT

The British Association for Behavioural and Cognitive Psychotherapies (BABCP) maintain a register of accredited CBT therapists on their website: www.cbtregisteruk.com

Cognitive Analytic Therapy (CAT)

The Association for Cognitive Analytic Therapy maintain a register of accredited CAT therapists: www.acat.me.uk/page/how+can+i+get+to+see+a+cat+therapist

Services for sexual minorities

Pink Therapy have a directory of therapists who work with gender and sexual diversity clients from an affirmative standpoint: www.pinktherapy.com

London Friend (www.londonfriend.org.uk) is an LGBT mental health and wellbeing charity. They offer counselling and support to LGBT people and for those who may be questioning their sexual orientation or gender identity. They also offer social and support groups in central London which provide a safe space for people to come together to discuss a range of issues affecting them, including coming out and questions about sexuality.

Switchboard (www.switchboard.lgbt) is an LGBT+ helpline, which listens to all kinds of calls. Examples of the things they can help with include:

- Information about support groups for someone who thinks they are trans or nonbinary.
- Support for a man who has been a victim of homophobic abuse, but has previously had a bad experience going to the police.
- Contact details for an LGBT-friendly therapist.
- Times and places for a local bisexual social group.

SECTION 33: THE ROLE OF THE COURSE TUTOR

Each trainee is assigned a Course Tutor. The tutor’s role is holistic: to support trainees across all the domains of the Course - on academic, clinical and research matters, and to monitor and support their personal and professional development.

The tutor’s role is critical. It should be a primary source of support for trainees, enabling the Course to monitor their progress and their welfare, and to respond appropriately if any concerns arise. While many of these concerns will be relatively easy to resolve, on occasion tutors need to support trainees through more serious problems (for example, major life events), and ensure that the Course meets its duty of care to trainees by supporting them in an appropriate and timely manner.

The Course expects trainees to maintain regular contact with their tutor, and it is part of the tutor’s duties to monitor this, and also to ensure that they make themselves available to trainees.

Course Tutor Duties

Monitoring trainee progress

In order to carry out their duties tutors need to make sure that they are fully apprised of their tutees progress in all domains. This means that they should read relevant supervisor and trainee feedback forms for each placement, ensure that they have reviewed MPR reports if they are not the placement visitor, and have checked the academic marksheet database to track progress with case reports and exams. It is especially important to do all of this prior to any meetings with the trainee.

Meetings between tutor and trainee

a) Timetabled meetings

Timing: Each term there are one or two timetabled lunchtimes when trainees meet with their tutors. Course Tutors are expected to keep these times free in their diaries and arrange for their tutees to see them at a specific time (usually by email). A minimum of 20 minutes should be set aside for each trainee.

If the tutor knows they will not be available for the timetabled tutor slots they should alert their tutees and arrange an alternative time; they should also ensure that the alternative time is as close as possible to the timetabled slot.

If the tutor’s unavailability is unpredictable (for example, because they are unwell) they should attempt to reschedule the meetings as quickly as is practicable.

If it is clear that the time set aside is not sufficient then the tutor should make arrangements to see the trainee at another time.

Content: The aim of the meeting is to discuss and reflect on the trainee's progression in all relevant domains of the course – academic, clinical, research and personal/professional development). If the trainee has current concerns these should also be picked up, discussed and managed appropriately.

Sometimes both trainees and tutors misunderstand the purpose of these meetings as 'troubleshooting'. This is an inappropriately narrow conception, largely because if things are going well there can be a temptation to assume that nothing needs discussing. Tutors are advised specifically and actively to enquire into progress in all domains, and to encourage trainees to talk as openly as possible.

Trainee non-attendance: If trainees do not attend for a scheduled tutor slot the tutor should contact them and ascertain the reasons for absence. Although it is the tutees responsibly to attend the meetings, it is also the tutor's duty of care to ensure that there is continuity of contact.

b) Developmental Reviews

The procedure for development reviews is detailed elsewhere. Essentially these are timetabled to take place at the start of the autumn term for both second and third year trainees. There is a template which needs to be completed by trainee and by the tutor, and the review should use this as the basis for an extended discussion. It is unhelpful to treat the review as a 'tick-box' – the review should be a chance for tutee and tutor to reflect on the progress the trainee has made to date and the objectives which should be held in mind for the coming year. To do this properly there should be an adequate amount of time set aside to do this – usually 40-45 minutes.

c) "Ad hoc" meetings

There is a risk that trainees and tutors restrict contact only to the designated slots. Although this will be sufficient for many trainees, it is important explicitly to let trainees know that they can contact the tutor at any time should there be matters which need discussing. This contact can be via phone or email – trainees should be clear that they do not have to wait until they are in college to contact their tutor in order to arrange a time to meet.

Responding to trainee problems

If trainees indicate that they are experiencing difficulties in any area of the course the tutor will need to consider how the problem is best managed, and to support this process. Usually some joint problem-solving between trainee and tutor is sufficient. Clearly there may be times when it is helpful to involve another member of staff (as below), but it is important to bear in mind that the role of the course tutor is holistic, and it is best to attempt to resolve issues without recourse to colleagues - there is an expectation that tutors are familiar with all aspects of course procedure. Hence a query about service related research does not automatically need to be passed to an academic colleague, just as a query about placement procedures does not automatically need to be answered by a clinical tutor.

Management of issues and events which adversely impact on trainee progression

From time to time issues emerge which will seriously impact on trainee progression. For example, it is fairly straightforward to identify a plan which accommodates to short periods of illness which result in trainees being unable to submit specific course assignments on schedule. However, longer periods of illness might make it difficult for a trainee to complete a placement, and there may be more serious implications both for the training and for the support the individual requires to complete training. When serious threats to trainee progression emerge Course Tutors will usually need to consult with senior colleagues or the course directors in order to identify not only the support which should be offered to trainees, but also for help planning any formal responses required by the course, especially where there is any question of varying course procedures to accommodate an individual's circumstances. Critically, such decisions are usually ones which the tutor themselves is not empowered to make, and hence there must be discussion or formal communications with the members of staff to whom authority is delegated. Broadly speaking, this means:

> **1) Problems that impact on academic regulations**: for example, requests for a significant variation in assessment deadlines, changes to assessment procedures, problems which could lead to course failure or potential disciplinary issues. All of these would need to be raised with the Chair of the Board of Examiners. The tutor themselves needs to take care not to act on behalf of the Chair unless clearly authorised to do so
>
> **2) Problems that relate to terms and conditions of employment:** for example, where a trainee is seriously ill and may need temporarily to withdraw from the programme, or trainees who are returning from maternity leave and requesting variations on the usual pattern of work. Such issues would need to be discussed with the Clinical Joint Course Director, who acts as the trainees' line manager on behalf of their employing Trust.

Support for trainees requiring extensions or deferrals to course work

Course tutors provide a supportive role to trainees who need to consider applying for an extension to coursework submission or deferring an exam, due to extenuating circumstances (ECs).

ECs are defined by UCL as "events which are sudden, unexpected, significantly disruptive and beyond your control and which may affect your performance at summative assessment." Common examples include illness, bereavement or a practical impediment on placement that delays producing a clinical report.

In exceptional circumstances, trainees can submit EC claims to request mitigation – usually this involves asking for an extended deadline on an assessment, or, occasionally, the deferral of an exam. The UCL webpages on ECs contain further information on this.

Applications for mitigation to all examinations and clinical reports (including the Service-Related Project) require a formal EC request via Portico. If a trainee needs up to one week of extension to a Clinical Report deadline, there is no obligation to consult the Course Tutor and they can simply submit the EC request themselves, most likely under the self-certification policy.

If trainees might need longer than a one-week extension, or if their EC request concerns examinations, they should discuss this with their Course Tutor at the earliest opportunity.

Interruption of study

If a trainee needs to interrupt their study they need to discuss this with their tutor and relevant information needs to be passed to the Chair of the Exam Board in a timely manner. The most common reasons for interruptions are maternity leave or serious illness.

Informing the course: Because an interruption of study constitutes an employment issue, trainees should be asked to contact the Clinical Joint Course Director (who will ensure that there is appropriate liaison with the employing Trust).

Informing Registry: Tutors must complete the interruption of study form with the trainee. This is a critical procedure; failure to complete this form can cause significant complications for the trainee and for the Course (because the period of study for the Doctorate is fixed at 3 years).

The form is downloadable from the staff intranet. Once completed it should be passed to the Chair of the Exam Board and the Senior Course Administrator (who will ensure that the trainee is interrupted from their studies through Student Records).

SECTION 34: DEVELOPMENTAL REVIEWS: FORMAT AND CONTENT

Background

Every trainee at UCL has a Developmental Review with their Course Tutor early in the second and third years.

The review should be seen as the culmination of other tutor meetings throughout the year. It is an opportunity for trainee and tutor to overview progress in academic, clinical, research and professional domains over the previous 12 months, identifying what has gone well and considering any areas that have been more difficult. It should aim to identify the opportunities for the forthcoming year, anticipated challenges and how they may be resolved or managed, any problems that might impact on, or interfere with, clinical training and any plans that need to be put in place to support the trainee. This will include a review of how things are going in terms of overall wellbeing and self-care and whether there is any specific support that the trainee has sought or might find helpful to seek. From a placement perspective, this review is particularly important with regards to essential competency requirements as it helps trainees to identify which areas of competence they have outstanding and therefore would benefit from reviewing with their placement supervisor for possible opportunities to meet them on the placements for that year.

The Developmental Review is also an opportunity for the tutor to give the trainee feedback about their performance to date, in relation both to Course expectations and criteria relevant to KSF gateways (as described below).

At the end of the appraisal, the tutor and trainee should specify any training objectives for the trainee for the next twelve months.

Content

The review procedure is congruent with the NHS Knowledge and Skills Framework (KSF) which is the performance management procedure adopted alongside Agenda for Change. This sets out the competences expected of psychologists at different levels of seniority; those of concern here are those that apply to trainee Clinical Psychologists. These are set out in the Table, grouped in relation to a series of dimensions along with a description of the skills that are expected to be demonstrated.

The formal KSF procedure would require trainees to pass through a ‘gateway’ in order to progress from the first year of training into the next. However, were there to be serious concerns in any area of competence we would follow course examination procedures. So although it is helpful for trainees and course tutors to be aware of the KSF[1], the process of a developmental review is not governed by KSF procedures.

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[1] http://www.bps.org.uk/system/files/documents/pact_knowledge_and_skills_framework.pdf

KSF Dimension	Description
Communication	Able to develop and maintain communication with people about difficult matters and/or in difficult situations
Personal and people development	Able to develop own skills and knowledge and provide information to others to help their development
Health, safety and security	Able to monitor and maintain the health, safety and security of self and others
Service development	Able to make changes in own practice and to offer suggestions for improving services
Quality	Able to maintain quality in own work and encourage others to do so
Equality and diversity	Able to support equality and value diversity
Promotion of health wellbeing and prevention of adverse effects on health and wellbeing	Able to plan, develop and implement approaches to promote health and wellbeing and prevent adverse effects on health and wellbeing
Assessment and care planning to meet health and wellbeing needs	Able to assess health and wellbeing needs and develop, monitor and review care plans to meet specific needs
Protection of health and wellbeing	Able to contribute to protecting people at risk
Assessment and treatment planning	Able to assess physiological and psychological functioning and develop, monitor and review related treatment plans
Interventions and treatment	Able to plan, deliver and evaluate interventions and/or treatments
Information collection and analysis	Able to gather, analyse, interpret and present extensive and/or complex data and information
Learning and development	Able to enable people to learn and develop
Development and innovation	Able to contribute to developing, testing and reviewing new concepts, models, methods, practices, produces and equipment

In practice these dimensions and competences overlap, and so the Developmental Review form does not set each of them out separately. However they are a useful prompt to thinking about the specific competences that trainees should be acquiring.

Preparing for the Review

The trainee should complete the Developmental Review Form ahead of the meeting, including noting down their main developmental needs for the upcoming academic year.

The form itself covers both the developmental review meeting at the start of the second year and the developmental review meeting at the start of the third year. This allows for continuity between meetings, such that trainee and course tutor can review the previous year's objectives and build on these in the developmental review at the start of the third year.

Process

The meeting should be scheduled in advance, and allow enough time for an active, reflective (and usually trainee-led) discussion. The review should also include time for the tutor to give feedback about the trainee's overall performance on the Course.

The meeting should take place face-to-face and one-to-one, though there may be instances where the line manager may also need to be present.

By the end of the meeting the tutor and trainee should be in a position to identify and specify any training objectives for the forthcoming year; these should be recorded in the personal development plan on the Developmental Review form in the section relevant for that year.

A copy of the completed Developmental Review form should be retained by the trainee and the tutor, and one copy stored in the trainee's college file. For the developmental review in the second year, trainee and course tutor should complete the first part of the form, which is for the second year developmental review – the section for the third year developmental review will remain blank. For the developmental review at the start of the third year, trainee and course tutor should update the form completed the previous year, completing the section for the developmental review for the third year.

SECTION 35:
EXPERTS BY EXPERIENCE AND CARER INVOLVEMENT ON THE COURSE

In the past the views of experts by experiences and carers of experts by experiences have been a secondary consideration when NHS services are planned, despite the fact that as the recipients of care they are in a good position to offer helpful advice to health professionals and managers. However well-intentioned a service, the acid test of its quality and acceptability is the experience of those who use it. Actively seeking out (and responding to) the views of experts by experiences makes considerable sense, not only because it is humane but also because services that are responsive, appropriate and acceptable to their clients are likely to be more efficient and effective.

This document sets out the ways in which the Course involves experts by experiences and carers in its organisation and in the teaching programme. In developing these links our guiding principle has been to avoid the tokenism which develops if experts by experiences are asked for their views without being fully informed of the background to the issues on which their opinion is sought, or are asked to comment on matters which are not within their experience. For this reason our strategy has been to build a experts by experience network, developing their roles as we gain experience with them, and they with us.

Experts by experience and carer committee
The experts by experience and carer committee meets two to three times a year; its aim is to coordinate and develop the input of experts by experiences across all the domains of the course – to the curriculum, placement experience, selection and research.

Membership comprises of a clinical tutor (who acts as a coordinator) and experts by experiences and carers recruited from local NHS trusts and voluntary organisations[1], as well as two trainee representatives. The aim is to build up a core membership of experts by experiences and carers who can represent as closely as possible the range of contexts and client groups with whom the course is preparing trainees to work. The meeting is co-Chaired by a member of staff and a experts by experience.

In order to integrate the experts by experience committee into the organisational structure of the Course, action points arising from its meetings are raised in the Course Executive Committee by the Academic Director, and are discussed as part of the agenda of the relevant course committees and Annual Course Review. If these proposals are seen as appropriate plans can be put in place to take them forward; if they are not taken forward then the reasons for this are fed-back to subsequent meetings of the experts by experience committee. Representatives from the experts by experience and carer committee also sit on each of the course committees (e.g. clinical practice committee, curriculum committee, selection committee).

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[1] Experts by experience are paid for their time at the rate for external speakers (joint lecturer rate)

Experts by experience input to teaching

Experts by experiences are involved in the teaching programme in a number of ways, from providing feedback on the content of the curriculum to co-developing and delivering specific teaching sessions throughout the three years. For example, within the first two weeks on the course, trainees are introduced to some of the members of the experts by experience and carer committee in an interactive teaching session focussed on the experts by experience perspective of attending for an initial psychology appointment.

Experts by experience input to selection

Experts by experiences are actively involved in the selection process. The UCL interview procedure comprises two separate panels: the first is an academic, clinical and professional interview (with course staff and supervisors), the second a ‘expert by experience’ panel, (with two experts by experiences and a member of the course staff). This is a group task, with questions and a rating system developed by the experts by experience and carer committee. Candidates’ scores in this interview contribute to their overall rating, and therefore to decisions about acceptance onto the programme.

The experts by experience and carer committee also consult on all aspects of the selection process, with a experts by experience representative attending and contributing to all selection committee meetings.

Experts by experience input to research

The experts by experience and carer committee are currently reviewing the process by which members of the group can consult with trainees on their major research project. If a trainee wishes to access the experts by experience and carer committee to consult on their research project (e.g. to obtain ethics approval), they are instructed to complete the *relevant form* and send this to Jarrod Cabourne (DClinPsy Experts by experience Lead)

Trainee consultation with experts by experience and carers while on placement

The course requires trainees to undertake consultations with experts by experiences and/or carers while on placement, outside of the usual therapeutic contact. The rationale for this is straightforward: although experts by experience involvement with the course is important, the most effective way for trainees to learn from experts by experiences is to gain direct experience while on placement. The consultation exercise is detailed in Section 10 of this handbook.

SECTION 36: THE HEALTH AND CARE PROFESSIONS COUNCIL (HCPC) AND CLINICAL PSYCHOLOGY TRAINING

The Health AND Care Professions Council (HCPC) regulates the use of the title ‘Clinical Psychologist’. This means that the use of this title is legally restricted to individuals who are on the HCPC register of practitioner psychologists.

This Section outlines the role of HCPC in regulating and accrediting courses, and the process of registration.

Trainees should familiarise themselves with the various documents produced by the HCPC. These specify the standards which entrants to the register are expected to meet (and are included as appendices to this handbook).

Registration: The role of the HCPC and the BPS

From 2009 Clinical Psychology became a regulated profession under the Health and Care Professions Council. The HCPC maintains a register of individuals entitled to use the title of ‘Clinical Psychologist’; entrants to the register need to have undertaken a training that enables them to meet the ‘standards of proficiency’ adopted by HCPC. On completion of training trainees will be able to apply for registration as a Clinical Psychologist with the HCPC on the basis of having undertaken and completed a recognised course.

The HCPC has granted the UCL Doctorate in Clinical Psychology open-ended approval, which means that graduates from the programme are deemed to have met the relevant standards.

Although all functions related to registration have passed from the BPS to the HCPC, the BPS will still play an important role in defining course content. This is because HCPC does not specify the content of professional trainings; it will continue to seek advice from the BPS on this. For this reason, the BPS will continue to be involved in accreditation visits through its training committee (the Committee on Training in Clinical Psychology: CTCP).

Course Accreditation

The HCPC visits all new UK courses in order to verify that they meet the appropriate ‘standards of education and training’ and enable trainees to achieve the ‘standards of proficiency’. Wherever possible the HCPC and the BPS coordinate their accreditation visits, with each body producing a separate report. The visiting teams meet with course staff and trainees, representatives of the University and Regional Psychologists, and meet supervisors. The reports comment on all aspects of course organisation, and make recommendations about any areas requiring improvement. If there are areas over which HCPC has concerns they will follow these up by asking courses to submit annual follow-up reports. The BPS will organise a follow-up visit if there are major concerns, but usually they operate on a 6-year visiting cycle.

The process of registration with HCPC

The HCPC website gives a good overview of the process of registration. The basic procedure is as follows:

Stage 1

The Course needs to notify the HCPC that a trainee has successfully passed all elements of the programme – specifically, the academic, clinical and research components of the course. Notification only takes place on successful completion of all course requirements, so this includes meeting any concerns raised in the thesis viva and (if required) submitting a revised thesis which has been passed by the relevant examiners and the Examination Board.

Stage 2

The Course will let new qualifiers know when it has notified HCPC, after which they can make their application for registration.

The HCPC application form is very straightforward, and has three main elements:

> a) Information about yourself, the title for which you are applying and the educational pathways relevant to this title.
>
> b) A character reference. This can be completed by anyone of appropriate standing (for example, HCPC suggestions include a Justice of the Peace or other judicial official, a minister of the Church, Rabbi, Imam or other religious official acceptable to the Council, or a registered health professional).This is not an exhaustive list and in most cases it is likely that trainees will find it easiest to ask the Course (in the form of their Course Tutor) to complete the character reference.
>
> c) A health reference. This is a statement to the effect that your health does not affect your ability to practice your profession. This must be completed by a doctor who is registered with the General Medical Council (GMC). It also needs to be a doctor who has known you for at least three years or has access to your medical records for the past three years. If this is not possible the doctor may need to carry out a medical examination in order to complete the health reference.

Both the character and health reference need to be dated within 6 months of the application itself, so while it is a good idea to obtain these in advance they would need to be repeated if there was significant delay in submitting the application itself.

Fees

These are detailed on the HCPC website, but it is worth noting that new graduates from approved courses currently receive a 50% discount on the cost of registration for the first two full professional years. It is possible that a GP (or equivalent) might charge a fee for completing the health reference.

Title to be used while awaiting registration

Anyone who wishes to be employed as a Clinical Psychologist and to use this title needs to be registered with the HCPC. Clearly this has implications if (as is likely) there is a time lag between completing the course, starting employment and gaining registration. During this time new qualifiers and those still completing specified elements of the course (for example, revising the thesis) can use the title ‘psychologist’, as this is not a protected title.

HCPC on the web

It is critical that all trainees look at the website of the Health Professions Council, which contains clear and up-to-date information about registration:

www.HCPC-uk.org/apply/psychologists

Documents to download

Aside from the application form itself, it is important to read the following documents, which are available on the HCPC website:

www.HCPC-uk.org/apply/uk/forms

They are also included as appendices to the Training Handbook.

- **Standards of Conduct, Performance and Ethics**
  These are the standards that applicants need to agree to keep to in order to be registered.

- **Standards of Proficiency**
  These are the professional standards which applicants must meet in order to be registered.

- **Standards of Continuing Professional Development**
  These are the professional standards which applicants must meet in order to stay registered.

SECTION 37: BPS ACCREDITATION CRITERIA

LEARNING OUTCOMES
STRUCTURE OF TRAINING

The BPS Accreditation Criteria are subject to periodic review. The most recent set of criteria was published in 2017.

This section is an extract from the BPS accreditation criteria, and focuses on expected learning outcomes and the structure of training.

The complete criteria can be found in Appendix 4 of this handbook.

What do clinical psychologists do?

Clinical psychologists aim to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and research.

Clinical psychology services aim to enable service users to have the necessary skills and abilities to cope with their emotional needs and daily lives in order to maximise psychological and physical well-being; to develop and use their capacity to make informed choices in order to enhance and maximise independence and autonomy; to have a sense of self-understanding, self-respect and selfworth; to be able to enjoy good social and personal relationships; and to access commonly valued social and environmental facilities.

Clinical psychology services aim to enable other service providers to develop psychologically informed ways of thinking; to use psychological knowledge to enhance and develop their professional practice to the benefit of their clients; to be able to enhance their sense of selfunderstanding, self-respect and self-worth; and to use psychological data to aid decision-making at a clinical, organisational and societal level.

Clinical psychologists also work with staff from other professional groups, including psychological therapists, to develop, monitor and improve practice, basing this on a breadth and depth of understanding of relevant psychological theory, and on the psychologist’s evaluative and reflective competencies.

Clinical psychologists as scientist practitioners

Clinical psychologists are more than psychological therapists. While many do practise psychotherapy at a high level, this is not a skill distinct to clinical psychologists, nor should it be.

The background and training of clinical psychologists is rooted in the science of psychology, and clinical psychology is one of the applications of psychological science to help address human problems. The ability to design and carry out innovative applied research is a skill developed to doctoral level in training and is important for the development and delivery of evidence-based practice. In addition, one element of research competence is critical evaluation of research activity.

While there are data that support many clinical activities, there are still major gaps in the knowledge base. One of the contributions made by clinical psychologists is the development and testing of new interventions and activities, based on psychological theory. Thus practice feeds and draws on research and theory that in turn influences practice.

Clinical psychologists as reflective practitioners
Clinical psychologists are cognisant of the importance of self-awareness and the need to appraise and reflect on their own practice. They are also aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development.

Use of clinical psychology services
Clinical psychologists work with individuals, couples, families, groups (therapeutic, staff, informal carers) and at the organisational and community level. They work in a variety of settings, including hospital wards, day centres, Community Mental Health Teams, NHS Trusts, primary and social care contexts and forensic settings, and with all age groups from very young children to older people.

They work with people with mild, moderate and severe mental health problems, developmental and learning disabilities, physical and sensory disability, and brain injury; people who have substance misuse problems and people with a range of physical health problems (including HIV and AIDS, cancer, heart disease, pain, diabetes).

Required capabilities and competencies
This section of the document has explained what clinical psychologists do, or in other words, the capabilities they demonstrate by using and applying their competencies and knowledge base. The statements in paragraph 1.1 set out the skills, knowledge and values trainee clinical psychologists need to develop during the course of their training, and, in paragraph 1.2, the learning outcomes that training programmes will need to have in order to enable trainees to achieve these goals. The competencies that clinical psychologists need in order to be able to work in the ways described are outlined in further detail in paragraph 1.3. Part 2 provides additional information on the knowledge base clinical psychologists draw on in their practice.

1. The required learning outcomes

1.1. Programmes must enable trainees to work as clinical psychologists with the range of clients and services specified below in a range of settings, especially those seen as having high priority within the National Health Service. Newly qualified clinical psychologists should understand and embrace the core purpose and philosophy of the profession as described in the document prepared by the Division of Clinical Psychology (DCP). They should be committed to reducing psychological distress and enhancing and promoting psychological well-being through the systematic application of knowledge derived from psychological theory and evidence. Their work will be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals. Programmes that meet these criteria will be considered to appropriately reflect current NHS policies such as *The Ten Essential Shared Capabilities Shared Capabilities*). Thus by the end of their programme, trainees will have:

1.1.1. The skills, knowledge and values to develop working alliances with clients, including individuals, carers and/or services, in order to carry out psychological assessment, develop a formulation based on psychological theories and knowledge, carry out psychological interventions, evaluate their work and communicate effectively with clients, referrers and others, orally, electronically and in writing;

1.1.2. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives;

1.1.3. The skills, knowledge and values to work effectively with systems relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community;

1.1.4. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare;

1.1.5. The skills, knowledge and values to conduct research that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work; and

1.1.6. High level skills in managing a personal learning agenda and self-care, and in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems.

1.2. In order to achieve these goals programmes will have the following learning outcomes.

1.2.1. Knowledge and understanding of psychological theory and evidence, encompassing specialist client group knowledge across the profession of Clinical Psychology and the knowledge required to underpin clinical and research practice.

1.2.2. A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.

1.2.3. Clinical and research skills that demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.

1.2.4. Professional competence relating to personal and professional development and awareness of the clinical, professional and social context within which the work is undertaken.

1.3. The following statements are intended as broad, high-level summaries of the required objectives that demonstrate competence.

1.3.1. Transferable skills

- 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. Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.
- Demonstrating self-awareness and sensitivity, and working as a reflective practitioner.
- Ability to think critically, reflectively and evaluatively.
- Making informed judgements on complex issues in specialist fields, often in the absence of complete information.
- Ability to communicate psychologically-informed ideas and conclusions clearly and effectively to specialist and non-specialist audiences, in order to facilitate problem solving and decision making.
- Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice.
- Drawing on psychological knowledge of complex developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.
- Ability to work effectively whilst holding in mind alternative, competing explanations.

1.3.2. Psychological Assessment

Developing and maintaining effective working alliances with clients, including individuals, carers and services.

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
- 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.

1.3.3. Psychological Formulation

- 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.

1.3.4. Psychological Intervention

- On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and

social circumstances of the client(s), and to do this in a collaborative manner with:
    - individuals
    - couples, families or groups
    - services/organizations
- Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, including those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating, psychosis and use of substances, and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.
- Ability to implement therapeutic interventions based on knowledge and practice *in at least two* evidence-based models of formal psychological therapy, of which one must be cognitive-behaviour therapy.
- Having an awareness of the impact of psychopharmacological and other clinical interventions.
- Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives.
- Implementing interventions and care plans through and with other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.
- Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to clients and carers.

1.3.5. Evaluation

- Selecting and implementing appropriate methods to evaluate the effectiveness, acceptability and broader impact of interventions (both individual and organisational), and using this information to inform and shape practice. Where appropriate this will also involve devising innovative procedures.
- Auditing clinical effectiveness.

1.3.6. Research

- Identifying, reviewing and critically appraising a substantial body of research evidence which is at the forefront of clinical psychology practice.
- Understanding applicable techniques for clinical research and advanced academic enquiry, including quantitative and qualitative approaches.
- Conducting service evaluation and small N research.
- Conducting collaborative research.
- Conceptualising, designing and conducting independent, original research of a quality to satisfy peer review, extend the forefront of the discipline, and merit publication: including identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis, reporting outcomes and identifying appropriate pathways for dissemination.
- Understanding the need and value of undertaking clinical research and development post-qualification, contributing substantially to the development of theory and practice in clinical psychology.

1.3.7. Personal and Professional Skills and Values

- Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.
- Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.
- Understanding the impact of differences, diversity and social inequalities on people’s lives, and their implications for working practices.

- Understanding the impact of one's own value base upon clinical practice.
- Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence, and accepting accountability to relevant professional and service managers.
- Managing own personal learning needs and developing strategies for meeting these.
- Using supervision to reflect on practice, and making appropriate use of feedback received.
- Developing strategies to handle the emotional and physical impact of own practice and seeking appropriate support when necessary, with good awareness of boundary issues.
- Working collaboratively and constructively with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.
- Monitoring and maintaining the health, safety, and security of self and others.

1.3.8. Communication and Teaching

- Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).
- Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.
- Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).
- Understanding 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 in formal settings.
- Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof.
- Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

1.3.9 Service Delivery

- 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 models and the contribution of consultancy 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.
- Working effectively in multi-disciplinary teams.
- Understanding of change processes in service delivery systems.
- Understanding quality assurance principles and processes.

2. The structure of training

2.1. It is essential that programmes provide a holistic experience of training that enables trainees to develop an integrated set of learning outcomes.

2.2. Programmes must provide a balanced and developmental set of academic, research and clinical experiences throughout training. The academic component needs to provide an integrated curriculum supporting the clinical and research training. The research training needs to be carefully planned and have sufficient time devoted to it to enable trainees to conduct research at a postgraduate level and to be in a position to contribute to the knowledge base of the profession. The clinical experience component of training needs to be delivered within the following framework.

2.3. The parameters described below aim to provide the framework for pathways through training, delineating client populations, clinical contexts and learning outcomes which contribute to a *generic* training in clinical psychology. It is important to recognise that the scope of clinical psychology is so great that initial training provides a foundation for the range of skills and knowledge demonstrated by the profession. Further skills and knowledge will need to be acquired through continuing professional development appropriate to the specific employment pathways taken by newly qualified psychologists.

2.4. Clinical experience will be gained in service delivery systems that offer a coherent clinical context. This will usually be a setting oriented towards a population defined by age (e.g. child, adult, older people), by special needs (e.g. learning disabilities, serious mental health problems, health-related problems, substance abuse), or by a service delivery focus (e.g. psychological therapy). In addition, clinical experience will be gained in a range of service contexts (primary, secondary and tertiary care, in-patient, out-patient, community), with service delivery models ranging from independently organised work through to integrated inter-professional working.

2.5. Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the NHS. These requirements will be shaped in part by National Service Frameworks and national policies, as well as by evidence of recruitment problems (for example, vacant posts) paying particular attention to specialities which have recruitment difficulties. National standards as set out by the Division of Clinical Psychology's Faculties and Special Interest Groups must also guide training patterns for each cohort of trainees. Not all trainees will necessarily follow the same pathway through training. Programmes therefore need to ensure, in consultation with local Faculties and SIGs and local placement providers, that – across the trainee cohort – there is optimum, effective and efficient use of all available placements.

2.6. Clients, services and modes of work:
The learning objectives described above need to be demonstrated with *a range* of clients and across *a range* of settings. These are not defined prescriptively, and there are multiple pathways through which the required goals may be achieved. The range of clients and settings is outlined below, together with an outline of the knowledge base that trainees need to develop to support their practice.

2.6.1. *Clients*
A fundamental principle is that trainees must work with clients across the lifespan, such that they see a range of clients whose difficulties are representative of problems across all stages of development. In this context, trainees must demonstrate competence to be able to work clinically with:

- a wide breadth of presentations – from acute to enduring and from mild to severe;
- problems ranging from those with mainly biological and/or neuropsychological causation to those emanating mainly from psychosocial factors
- problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions; *and*

- clients from a range of backgrounds reflecting the demographic characteristics of the population.

Trainees will need to understand the impact of difference and diversity on people's lives (including sexuality, disability, ethnicity, culture, faith, cohort differences of age, socio-economic status), and their implications for working practices.

It is also essential that trainees work with:
- clients with significant levels of challenging behaviour;
- clients across a range of levels of intellectual functioning over a range of ages, specifically to include experience with clients with developmental learning
- disabilities and acquired cognitive impairment;
- clients whose disability makes it difficult for them to communicate; *and*
- carers and families.

2.6.2. *Service delivery systems*
Trainees must undertake substantial pieces of clinical work over a substantial period of time in each of a range of settings, including:
- in-patient or other residential facilities for individuals with high dependency needs, both acute and long term;
- secondary health care; *and*
- community or primary care.

2.6.3. *Modes and type of work*
- direct work;
- indirect, through staff and/or carers;
- work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;
- work (practice, teach, advise) in *at least two* evidence-based models of formal psychological therapy. This must include cognitive-behaviour therapy and at least one other evidence-based approach, such as brief psychodynamic or interpersonal psychotherapy, systemic, or integrative interventions.
- work with complexity across a range of perspectives, demonstrating flexibility in application of whichever approach is most appropriate for the client or system; *and*
- be critical of their own approach, and aware of how to practice in the absence of reliable evidence, as well as being able to contribute from their work to the evidence base.

2.6.4. *The UK health care context and the application of clinical psychology*
Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken, including for example:
- legislation relevant to England and the devolved nations (e.g. Mental Health Act, Mental Capacity Act, Children Act, Disability Discrimination Act, Health and Social Care Act, Data Protection Act, employment legislation, etc.);
- Government policy statements (e.g. National Service Frameworks, Ten Essential Shared Capabilities, Knowledge and Skills Framework, etc.); *and*
- organisation of the NHS and social care in England and the devolved nations.

2.7. Where programmes are providing training for the Society's Statement of Equivalence in Clinical Psychology through the accredited programmes route, they must ensure that the quality assurance arrangements pertaining to this aspect of their provision are broadly consistent with those of the main, accredited programme.

2.8. Of the total programme time (exclusive of annual leave), at least fifty per cent must be allocated to supervised clinical experience. In addition, at least ten per cent must be available to trainees for self-directed study throughout the programme. Of the remaining time there must be an appropriate balance between research activity, and learning and teaching, to ensure that the criteria outlined in Sections 10 and 11 can be met.

SECTION 38: TRAINEE RECORD KEEPING

a) PAPERWORK REQUIRED FOR ALL PLACEMENTS
b) KEEPING CONTACT DETAILS UP TO DATE
c) CONTENT OF TRAINEE ELECTRONIC FILES

PLACEMENT PAPERWORK
REQUIREMENTS OFTRAINEES, SUPERVISORS AND COURSE STAFF

For each six-month placement period there must be a complete set of paperwork uploaded to the Electronic Trainee File System (ETFS). This is not an option; it is a requirement of the Examination Board. In order for the Board to pass a placement undertaken by a trainee, all the relevant paperwork must be in their file (without the paperwork, the placement could be deemed a technical 'fail').

Although paperwork is collated for your time on the Course, trainees are strongly advised to maintain a file of their own. After completion, it is possible that trainees will seek registration with professional bodies, who may ask for evidence of clinical work undertaken and passed.

A chart showing the deadlines for submission of placement paperwork can be found at http://www.ucl.ac.uk/dclinpsy/clinicalplacement/clinplacement_documents/placement_and_paperwork_dates. As above, these are not optional deadlines – they are Examination Board requirements.

Paperwork for a six-month placement period and schedule for submission

Paperwork	**Person responsible for uploading to the ETFS**	**When**
Placement contract	Trainee	Submitted within 4 weeks of the start of the placement
MPR report	MPR visitor Note: if MPR visitor is one of our team of Associate Clinical Tutors, MPR report to be uploaded by Clinical Placements Coordinator)	About mid-way through the placement (January/early February for Autumn-Spring placements; late June/early July for Summer placements) MPR visitor should pass a copy to both supervisor and trainee within 2 weeks of the review taking place
Clinical portfolio	Trainee	The log of clinical experience should be available for inspection at the MPR

		A final version of the portfolio should be submitted within 2 weeks of the end of the placement
Supervisor feedback form	Trainee	The form must be discussed verbally at the End of Placement Review It must be submitted within 2 weeks of the end of the placement. The trainee should ensure that it is the supervisor-signed version that is uploaded to the ETFS (typed signatures are not appropriate), and all details (e.g. number of days on placement, start/end dates) must be present and correct.
Trainee Feedback form	Trainee	The form must be discussed verbally at the End of Placement Review. It must be submitted within 2 weeks of the end of the placement

Paperwork for a one-year placement and schedule for submission

For the purposes of the Examination Board, trainees on a one-year placement are undertaking two 6-month placement periods. This means a slightly different pattern of paperwork, as follows:

Paperwork	**Variations from the standard set of paperwork detailed above**
Placement contract	If the work to be undertaken throughout the year does not change significantly, only one contract is needed In placements where the work changes significantly at the six-month point, a second contract should be submitted
MPR	There should be two MPR reports
Clinical portfolio	The log should be available for each MPR meeting. One copy should be uploaded to the file system half-way through the placement, and the final copy should be submitted at the end of the placement.
Supervisors Feedback form	Two feedback forms should be submitted: 1) The first covers the initial six-month placement period: • if there are no serious concerns the short feedback form* can be used: • if there are any concerns about trainee progress, the standard feedback form should be used The form should be submitted after the first 6-month placement period has been completed. 2) A form is submitted at the end of the placement, and covers the second placement period. The standard feedback form should be used. This should be submitted within two weeks of the end of the placement
Trainee Feedback form	Only one form is submitted, at the end of the 12 month period

* see Section 15 of this handbook for more details

Additional paperwork required in the final placement period of the 3rd year of training

Along with the paperwork described above, one additional piece of paperwork needs to be submitted in early September of the final year. This is the 'Interim Feedback Form' (www.ucl.ac.uk/dclinpsy/docs/placement_documents/plac_interim_3rdyr).

This form is very brief, and is used to indicate whether the supervisor anticipates that the placement will be passed or failed. This form is needed because the Board meets about three weeks before the end of the final placement; since supervisors will not have completed the standard feedback form, the Board needs a formal indication of how the placement has progressed.

The Board uses the interim feedback form to *provisionally* pass or fail trainees. This decision is ratified when we receive the standard form (which is, of course, completed at the end of the placement).

NOTIFYING THE COURSE AND UCL OF ANY CHANGES OF ADDRESS

Trainees must make sure that the Course has all relevant contact details (including phone, mobile phone and email).

Trainees are responsible for ensuring that any change in contact details is notified both to the Course *and* UCL Registry, via Portico. Trainees who are also employees of Camden & Islington NHS Trust must also ensure they update their HR where necessary, as they will hold their own records which are separate to those held by the Course.

The Course does not contact Registry to update contact information on Portico – it is the trainee's responsibility to do this. Failure to update contact details so could mean that critical documentation or communications are not received.

CONTENT OF TRAINEE ELECTRONIC FILES AND ANY RELEVANT DATABASES HOLDING INFORMATION ABOUT TRAINEES

Each trainee has a file held on the ETFS, accessible through either a UCL computer and remotely via UCL's Desktop Anywhere system. Full details can be found at: www.ucl.ac.uk/dclinpsy/docs/electronic_file_system/electronic_file_system (this hyperlink is included in the 'quick links' section of the course website).

The file contains:
- their application form to the course and references
- where necessary, any relevant correspondence with Camden and Islington NHS Trust and UCL Registry
- placement paperwork (as described above)
- mandatory training certification
- case report marker sheets/grades
- documentation relating to the CBT Pathway (if applicable)
- documentation pertaining to the research component of the course
- a record of attendance, encompassing annual leave, sickness absence and any other approved leave

SECTION 39: CLAIMING FOR TRAVEL EXPENSES

General information about travel claims and benefits
You can claim for travel within the northern part of the London SHA Region, or for travel to a placement outside this area to which you have been allocated by the Course. If you are undertaking travel outside of the Region for other reasons you should discuss this with the Clinical Placement Coordinator/International Liaison Administrator to check whether you can make a claim.

You can claim for all forms of transport:
- public transport
- bicycle
- car/motorbike

You can also claim for parking if you need to use a car while carrying out clinical duties, or the placement is inaccessible or very difficult to reach by public transport (i.e. where there is a requirement to use a car in order to carry out your clinical duties).

You can only claim for the London Congestion Charge if your clinical duties require you to travel by car within the charging zone. This means that you cannot claim the charge simply because your placement lies within the zone.

Taxis
In line with standard NHS practice, you are NOT entitled to claim for taxis. This ruling is varied only under exceptional circumstance, and is never varied retrospectively. If supervisors suggest clinical work that involves taking a taxi, clear this with the college first; it is very unlikely that we would agree to pay.

In special circumstances we will consider paying for travel by taxi if this is justified *in advance*, and where it is clear that public transport is not an option. Examples include individuals with a disability or injury that makes tube/bus access difficult or impossible.

Travel connected to research
The principles that govern claims for travel for research purposes are essentially the same as for placement-related travel. However, your placement supervisor is not in a position to authenticate travel linked to research. As such, you should submit claims separately from placement travel (but using the same travel form) to the Clinical Placement Coordinator/International Liaison Administrator(after which it will be signed-off by Katrina Scior).

Travel outside the region for thesis research purposes is not automatically funded (because your contract with the NHS only covers travel within the region). For this reason, you will need to include the estimated cost of research related travel in the Proposal for Research Expenses Form, submitted at the start of term 2 of the 2nd year. Your internal supervisor will need to approve the costings and sign the form before this is passed to the Research Committee for approval. For example, a one-off visit to a site close to London may well be funded, but this may not be the case for research that requires repeated long-distance visits for data collection.

Bicycle Salary Sacrifice Scheme (Home Fee trainees only)
Eligible Trust staff may be able to purchase a bicycle from participating stores up to the value of £1000. Staff can then make repayments over a 12-month period through monthly salary deductions. For further details, contact C&I HR on 020 3317 7081.

Principles underpinning travel claims

1) The NHS/UCL does not pay its staff to travel to their place of work (usually referred to as their ‘base’).

For the purpose of calculating travel claims, a trainee’s base is the college they attend. So - in everything that follows, ‘base’ means UCL.

You are not paid travel expenses for your travel to and from UCL. This is because UCL is your base - as above, the NHS does not pay you to travel to your place of work.

2) The NHS/UCL *does* pay employees travel expenses when they are ‘out of pocket’ as a consequence of carrying out their regular duties.

Although attendance at college is also part of regular duties, for the purposes of calculating travel claims the focus is on travel to placement.

The basic question is whether you are spending more to travel to placement than you would to travel to base (i.e. whether you are ‘out of pocket’ as a consequence of carrying out your duties).

Calculating your entitlement to travel expenses – the ‘out-of-pocket’ test
Calculating travel expenses involves determining whether you are ‘out of pocket’. If you are, you can claim the *additional* expense; if you aren’t, you cannot make a claim.

The basic principle is very straightforward:

> 1) Calculate the actual daily cost of travel from home to college (‘base’), based on using your usual mode of transport
> 2) Calculate the actual daily cost of travel from home to placement, based on using your usual mode of transport

If (2) is greater than (1) you are you out of pocket, and you can claim the additional amount you are spending to get to placement. For example, if travelling to placement costs £6 a day and travel to UCL costs £4 then you can claim £2.

Putting this into practice
In outline the ‘out of pocket’ principle is fairly straightforward, and most trainees should have little difficulty calculating their entitlement. However, there are circumstances where it can be a little more complicated; the examples that follow cover most eventualities. Before looking at these, it is helpful to consider some more principles.

1) Usually the journeys you compare in the ‘out of pocket’ test should be a ‘like-for-like’ comparison (i.e. comparing the same mode of transport and the same basis for calculating fares or mileages).

2) If the journeys being compared do not use the same mode of transport there needs to be a reason for this. For example, it would be very unusual to travel to UCL by car, but it might be sensible to use your car to travel to placement. If this is the case you can compare the cost of a tube journey to UCL with a car journey to placement.

3) All calculations should be honest reflections of travel costs from home to base. There is an important principle: you should not artificially manipulate the ‘out of pocket’ test order to minimise the cost of home-base travel (with an eye to ensuring that home to placement travel costs exceed home to base costs). For example, you should not carry out the ‘out of pocket’ test by:

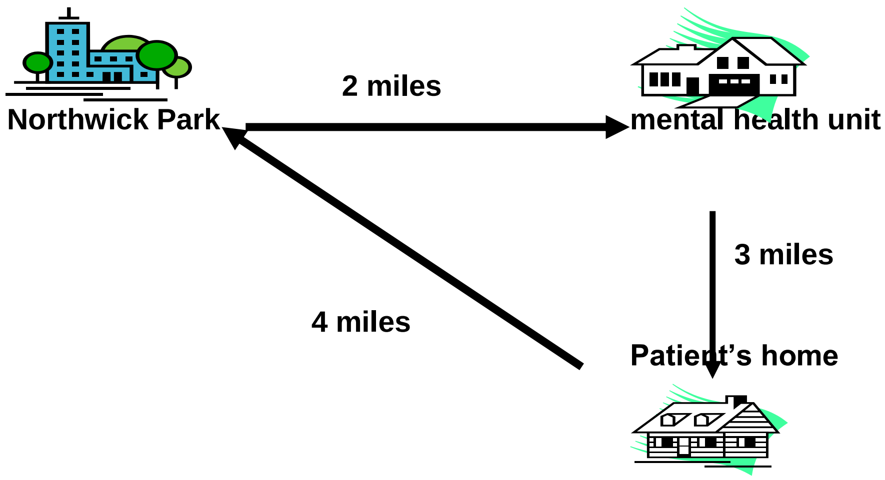
- comparing the cost of a bus journey from home to base with the price of a tube journey from home to placement if (in fact) you do not normally take a bus, or taking a bus would take so much longer than the tube trip that it is impractical
- calculating home to base travel costs as zero because you walk and contrasting this with a tube journey to placement – unless you live very close indeed to base, walking every day is not very likely
- comparing the home-base costs of car-pooling with one or more colleagues with the cost of an individual driver taking a car journey from home to placement – like-for-like means calculating the rates on the basis of one person driving both journeys

4) There might be circumstances where someone has a home-base travel cost that is genuinely low. For example, they might live close enough to UCL to walk, or their usual mode of transport to college is by bicycle, while home-placement travel is undertaken by tube. If this is the case the trainee should advise college so that their forms are not misconstrued by UCL or by NHS Trust auditors as an attempt to artificially manipulate the claim (as in (3) immediately above).

Adding the cost of travel once you are on placement

Once you have arrived at placement there may well be journeys that you undertake in order to fulfil your clinical duties. You are eligible to be paid in full for this travel (though if you are travelling on public transport there will be a cap on payment, as described below).

The easiest example is to think how this works for a car or bike journey. Your placement is at Northwick Park, and you are travelling by car. During the day you travel 2 miles to a mental health unit. From there you visit a patient at their home, and then return to Northwick Park. You can claim in full for all this travel – it would be 2 + 3 + 4 miles = 9 miles.



If you are making this claim on public transport the same principle applies, but you need to remember that if you are using public transport the actual cost of travel is capped - whether you are using an Oyster travel card or an Oyster pay as you go card there is a daily cap (equivalent to the cost of a daily travel card).

This means that you cannot make a claim for any one day that exceeds the daily cap. This might seem obvious, but consider the following:

A trainee lives in Brixton and is on placement in Edgware. Let's assume that they are using an Oyster pay as you go card:

Brixton – Goodge Street (i.e. to UCL)	£2.50
Brixton – Edgware	£4.10
	Daily out of pocket expense @ £1.60 each way = £3.20

Once they arrive on placement they can claim back the actual cost of clinically-related travel (for example, travel to a local clinic, or to a client's home, and so on). However, they are travelling on an Oyster card, so the *actual* cost of the whole day's travel cannot be greater than the daily cap (since this is the maximum amount that they would be charged). Just to make this clearer with a slightly unlikely scenario:

After the trainee above arrives at Edgware they make 5 return journeys to Colindale on the tube. Computed individually at the pay as you go rate, each journey costs £1.40 single, so *in theory* that adds up to £14.00.
When this trainee makes a claim for the day, they might think that they can claim their out of pocket expense for travel from home to placement (£3.20), plus £14 for travel once they arrive on placement, making a total claim of £17.20.

However, the daily cap (which, in reality, is what determines their actual spend for that day's travel) for zones 1-5 (including peak time travel) is £15.80[1], so that is the maximum that can be claimed (because that is also the maximum that the trainee would have actually spent).

Travel Cards (Oyster weekly/monthly/annual)
You cannot base a travel claim on the use of a weekly/monthly/annual Oyster travel card. The reason for this is that these cards allow you to travel at evenings and weekends, and the NHS travel regulations make it clear that this 'benefit in kind' is not permissible (this follows from theprinciple that the NHS will not pay for your travel on non-NHS business).

You can purchase a travel card and use it to travel from home to UCL. In many cases this card will cover travel from home to placement, and hence trainees are not 'out of pocket', and will not submit a travel claim.

If travel to placement means that the "home to placement" journey is longer than the journey from "home to UCL", you should not purchase a travel card that covers this additional distance. An example should make this clearer.

Imagine you live in Brixton (Zone 2) and have a weekly travel card for zone 1-2 (which covers your travel to UCL). You are then allocated a placement in Edgware (Zone 5).

Purchasing a Zone 1-5 travel card is not advised, as you will not be able to use this to compute travel claims. Instead you should continue to purchase a zone 1-2 travel card and follow the instructions immediately below.

Computing the out of pocket test when you have a travel card used for travel from home to UCL
Oyster Travel Cards allow you to travel within a set number of zones (e.g. Zone 1 to 3). If you travel beyond these zones then the Oyster card automatically adds an extension fare, and this is recorded on the printouts you can obtain from tube travel offices/your online account (these printouts then constitute evidence of travel when you submit your claim).

So actually, the procedure is quite simple. If you have an Oyster travel card that covers you for travel between home-UCL, and travel to your placement involves travel outside the zones covered by the travel card, the claim you make is for the extension fare.

Again, imagine you live in Brixton (Zone 2) and have a weekly travel card for zone 1-2 (which covers your travel to UCL). You are on placement in Edgware (Zone 5), and use your travel card for this journey. This means that on the days you travel to placement you are automatically charged the extension fare. This extension fare can be claimed as your 'out of pocket' expense (and as it will appear on printouts of your Oyster travel this will constitute the receipt you need to submit with your claim).

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[1] Up to date details of PAYG fare capping can be found at https://tfl.gov.uk/fares-and-payments/oyster/using-oyster/price-capping. Other stated Oyster costs in this document are for example only; up to date costs can be found at https://tfl.gov.uk/fares-and-payments/fares

Examples of claims

The examples that follow demonstrate how you compute a claim. Although the focus is on tube and car journeys, claims for other forms of transport are based on the same principles.

The examples show that there are different ways of computing the "out of pocket" test, and you will notice that different comparisons come up with different results for the out of pocket test. This might seem a little confusing, but usually it reflects the different pricing systems for travel cards and pay-as-you-go tickets.

We expect trainees to make use of tickets that result in the lowest price for journeys, so you will need to justify claims based on using of tickets which result in more expense than an obvious alternative.

Home Tufnell Park, placement Edgware Community Hospital
Oyster pay as you go

		usual method of travel	Oyster pay as you go return fares (peak time)	out of pocket test	Claim per day
Home – Base	Tufnell Park – Goodge St	Tube	£4.60	Travel to placement is 20 pence cheaper per day	No Claim
Home – Placement	Tufnell Park – Edgware Community Hospital	Tube	£4.40		

Home Tufnell Park, placement Edgware Community Hospital
comparing costs of tube to cost of car journey

		usual method of travel	Oyster pay as you go return fares (peak time)	out of pocket test	Claim per day
Home – Base	Tufnell Park – Goodge St	Tube Zone 2- Zone 1	£4.60	Travel to placement is 52 pence cheaper per day	No Claim
Home – Placement	Tufnell Park – Edgware Community Hospital	Driving (8.5 miles each way = 17 miles @ 0.24 per mile) = £4.08	£4.08		

Home Oval, placement Northwick Park
comparing Oyster pay as you go

		usual method of travel	Oyster pay as you go return fares (peak time)	out of pocket test	Claim per day
Home – Base	Oval – Goodge St	Zone 2-Zone 1	£4.60	Travel to placement is £1.60 more per day	£1.60
Home – Placement	Oval – Northwick Park	Zone 2 to Zone 4 (via Zone 1)	£6.20		

Home Oval, placement Northwick Park
comparing costs of tube to cost of car journey

		usual method of travel	Oyster pay as you go return fares (peak time)	out of pocket test	Claim per day
Home – Base	Oval – Goodge St	Zone 2-Zone 1	£4.60	Travel to placement is £2.36 pence more per day	£2.36
Home – Placement	Oval – Northwick Park	Driving (14.5 miles each way = 29 miles @ 0.24 per mile) = £6.96	£6.96		

Making Claims

Blank claim forms are downloadable from the DClinPsy Course website.

You need to submit two forms:

a) An “out-of-pocket’ claim form (so that we can be clear how what you are claiming for has been computed)
b) A travel subsistence expenses claim form, signed off by yourself and placement supervisor (or in the case of research claims, your research supervisor)

a) “Out-of-pocket’ calculation: This form is self-explanatory. The space for notes allows you to explain any non-standard aspects of the journey.

b) Travel subsistence expenses claim form: The example shows where the various costing are entered. The term ‘excess’ refers to the out-of pocket’ calculation.

If you are claiming mileage rather than a fare the same principle applies – enter the actual mileage and the “excess” cost.

Once you have entered the details of a regular journey you can save time by referring to this as ‘journey 1’ or ‘journey 2’ (as has been done in the example).

Two completed examples of both forms follow. The second of these shows how to put in a claim form for a car. Because the out-of-pocket test in this example is not computed using ‘like-for-like’ modes of travel it is tricky to register the basis for the claim on the form – for that reason (as in the example) you should write in a note referring to the out of pocket test form.

Frequency of submissions

Home fee trainees should submit their travel claimsmonthly, via email, to placements-admin@ucl.ac.uk, by no later than 10am on the 5th of each month. If the 5th falls on a weekend/public holiday, then your claim should be received by no later than 10am on the Friday before.

The International Liaison Administrator will notify international trainees directly of the deadlines for the placement travel claims. International trainees should submit their travel claims via e-mail to dclinpsy_international@ucl.ac.uk
Late claims: Home fee trainees are expected to submit forms monthly and international trainees approximately every three months. If you submit claims which cover a period longer than one month or three months for international trainees, you will need to explain in writing why the claim has been delayed. Claims backdated for longer than 3 months will not usually be passed to Camden and Islington/UCL Accounts Payable Team unless there is a compelling reason for the delay.

Countersigning of travel forms

Your placement supervisor must countersign your travel form for placement related travel before it is handed in to college. When they do this they are officially confirming that you have undertaken the journeys for which you are making a claim (there is a space for this at the bottom of the form).

Entering all the required fields

You must enter all the relevant fields, including the totals (otherwise we will return the form).

Travel rates for cars, motorcycles and bicycles

Current rates are:

Car	Home fee trainees: 24 pence per mile. International trainees: 45 per mile for the first 10,000 miles in a tax year and 25p per mile thereafter
Motorbike	Home fee trainees: up to 125 cc – 17.8 pence per mile; over 125 cc – 27.8p per mile. International trainees: 24p per mile
Bicycle	20 pence per mile for both Home fee and international trainees

Receipts

You need to include receipts (print-outs of your Oyster journey history or rail tickets to cover the period the claim is for) for all journeys made by public transport. These receipts should match the actual journeys you have undertaken (and hence there needs to be a match between the out of pocket test and your receipts).

You can obtain a printout of your history of purchase/travel using an Oyster Card from any Underground ticket office, or via your online Oyster account. Please remember to highlight each journey and cost on the Oyster journey statement. Please also download your Oyster journey regularly (ideally every month) as TFL only retain journey data for 8 weeks.

If you use your contactless debit/credit card for tube, bus or rail travel, please ensure that you register your card with TFL so you can download your journey history.

We expect evidence of travel for at least a proportion of journeys, and forms claiming for multiple public transport journeys but with no accompanying receipts may not be accepted.

Where relevant you will need to keep, and submit, receipts for parking with your claim.

Fraudulent claims

Submission of a fraudulent claim is a serious matter, and under some circumstances can lead to dismissal and potentially prosecution.

We check all claims carefully, and they are audited by Camden and Islington/UCL. Although it might be tempting to embellish claims, you should be aware that the potential consequences far outweigh any possible financial gain.

Example of "Out of pocket test" form

Trainee name	John Smith
Trainee cohort	2009
Home (including postcode)	37 Tooting High Street, SW17 0SU
Placement (including postcode)	St Ann's Hospital, St Ann's Road, Tottenham, N15 3TH

Out of pocket test

	usual method of travel	full details of journey (inc tube stations and zones)	usual ticket types/ mileage	cost per day	out of pocket test	Claim per day
Home to UCL	Tube	Tooting Broadway – Goodge St, zones 1-3	Pay as you go £5.40 a day	£5.40	£2.40	£2.40
Home to Placement	Tube + Bus	Tooting Broadway – Seven Sisters (zone 3) Bus Seven Sisters to St Ann's	Pay as you go £5.40 Bus £1.20 each way	£7.80		

Notes

Sample Travel Subsistence Expenses Claim Form

CAMDEN AND ISLINGTON NHS FOUNDATION TRUST EXPENSE CLAIM FORM

Payroll number: **XXXXXXXXXX**		Job title: **Trainee Clinical Psychologist**	Band / Grade**: 6**
Mr/Mrs/Miss/Ms : **Mr**	Surname: **Smith**	First Name: **John**	
Department: **UCL**	Car Details (Make, Model, Engine Size, Registration Number):		
Home Address: **37 Tooting High Street, SW17 0SU**	Base: **UCL**		Placement: **St Ann's Hospital, St Ann's Road, Tottenham, N15 3TH**
Mode of transport from home to base: **Tube**	Mileage from home to base (if claiming mileage):	Public transport rate from home to base (if claiming tube/bus/rail fares): **£5.40**	**Please note that excess travel claims are eligible for re imbursement. Claimants may only claim for any work related travel which exceeds their usual home to base travel costs. The difference in mileage / cost may be claimed.**

EXPENSES DETAILS

Details of journey / expenses **To submit on a monthly basis**		**Expenses** **Receipts to be attached**						**Additional costs** **Receipts to be attached**	
Date	Reason for journey / expense. Please include the details of journey undertaken including the start and end destination (full postal code)	Actual Miles	Excess miles being claimed	Passenger miles	Passenger name	Public transport (tube/bus/national rail) cost	Excess cost being claimed	Subsistence	Other (please specify)
2/4/10	**Home to placement** **Tooting High Street SW17 0SU to St Ann's Hospital, St Ann's Road N15 3TH**					**£7.80**	**£2.40**		
3/4/10	**Home to placement** **Tooting High Street SW17 0SU to St Ann's Hospital, St Ann's Road N15 3TH**					**£7.80**	**£2.40**		
4/4/10	**Home to placement** **Tooting High Street SW17 0SU to St Ann's Hospital, St Ann's Road N15 3TH**					**£7.80**	**£2.40**		
Totals							**£7.20**		

Example of “Out of pocket test” form

Trainee name	Jane Jones
Trainee cohort	2009
Home (including postcode)	Perry Hill, Sydenham, SE26 4PU
Placement (including postcode)	Hillingdon Hospital, UB8 3NN

Out of pocket test

	usual method of travel	full details of journey (inc tube stations and zones)	usual ticket types/ mileage	cost per day	out of pocket test	Claim per day
Home to UCL	Tube	Sydenham – Goodge St, zones 1-3	Pay as you go £5.40	£5.40	£6.32	£6.32
Home to Placement	Car	Sydenham – Hillingdon	24.4 miles @ 0.24 mile = £5.86	£11.72		

Notes

Sample Travel Subsistence Expenses Claim Form

CAMDEN AND ISLINGTON NHS FOUNDATION TRUST EXPENSE CLAIM FORM

Payroll number: **XXXXXXXXXX**	Job title: **Trainee Clinical Psychologist**	Band / Grade**: 6**	
Mr/Mrs/Miss/Ms : **Ms**	Surname: Jones	First Name: **Jane**	
Department: **UCL**	Car Details (Make, Model, Engine Size, Registration Number): **Ford Fiesta, 1.2 litre, LT08 WER**		
Home Address: **Sydenham, SE26 4PU**	Base: **UCL**	Placement**: Hillingdon Hospital, Hillingdon UB8 3NN**	
Mode of transport from home to base: **Tube**	Mileage from home to base (if claiming mileage):	Public transport rate from home to base (if claiming tube/bus/rail fares): **£5.40**	**Please note that excess travel claims are eligible for re imbursement. Claimants may only claim for any work related travel which exceeds their usual home to base travel costs. The difference in mileage / cost may be claimed.**

EXPENSES DETAILS

Details of journey / expenses To submit on a monthly basis		**Expenses Receipts to be attached**						**Additional costs Receipts to be attached**	
Date	Reason for journey / expense. Please include the details of journey undertaken including the start and end destination (full postal code)	Actual Miles	Excess miles being claimed	Passenger miles	Passenger name	Public transport (tube/bus/national rail) cost	Excess cost being claimed	Subsistence	Other (please specify)
2/4/10	**Home to placement** **Perry Hill, Sydenham SE26 4PU to, Hillingdon Hospital, UB8 3NN** **Please refer to out of pocket test form for computation of excess cost**	24.4 miles each way = 48.8 @ 0.24 mile = £11.72 return					**£6.32**		
3/4/10	**Home to placement** **Perry Hill, Sydenham SE26 4PU to,**						**£6.32**		

	Hillingdon Hospital, UB8 3NN								
4/4/10	**Home to placement** **Perry Hill, Sydenham SE26 4PU to,** **Hillingdon Hospital, UB8 3NN**						**£6.32**		
Totals							**£18.96**		

SECTION 40: TERMS AND CONDITIONS OF EMPLOYMENT FOR TRAINEES

Employment, Annual Leave and Attendance

There are two routes of entry into the Course, one for trainees who originate from within the EU, and the other for those based outside the EU. Although all trainees follow exactly the same programme, there is a difference in employment status. Students from the EU are funded by NHS London and are employed through the NHS); those trainees from outside the EU will have alternative sources of funding, and are not employed by the NHS.

Although this Section applies only to trainees who are employed through the NHS, it is assumed that all trainees will follow the guidance on attendance requirements outlined below.

EMPLOYMENT

Trainees who are in receipt of funding from NHS London are full-time salaried employees of the NHS, as well as being full-time students registered at UCL. This dual status is very unusual and potentially confusing, because it confers student status for some purposes, but also the rights - and hence the obligations - of a full-time salaried employee.

This Section gives you information about basic terms and conditions. It is not intended as a substitute for the contract with Camden & Islington Foundation Trust, which sets out terms and conditions in a formal manner.

Funding, contracts and line management

Trainees are funded by NHS London. Because the Strategic Health Authority cannot directly employ trainees, it commissions a local Trust to act as the employing Trust and hence to manage all trainee human resources issues related to this employment. For this reason all HR functions are carried out by Camden and Islington Foundation Trust.

Contract extensions: Your contract usually allows for three years of full-time funding. Contracts can be extended only under specific circumstances, and usually for no more than 12 months. There is further information about this at the end of this Section.

Line management: Janice Williams is 2023 Cohort Trainee Line Manager / Fran Brady is 2022 Cohort Trainee Line Manager / Kat Alcock is 2021 Cohort Trainee Line Manager

ATTENDANCE REQUIREMENTS

At College and Placement

As full-time salaried NHS employees, trainees are paid for **all** the activities that take place in the working week. This includes time spent in clinical placements, attending lectures in college, undertaking research, undertaking academic study (and even time spent sitting exams).

This is a very unusual situation; not only are trainees paid for activities which are intuitively identified as employment ("doing clinical work"), but also for activities usually labelled as "being a student". Trainees need to keep in mind that they are paid for all activities related to training, whether "work-like" or "student-like", and that whatever the activity, employment conditions apply. The main reason for being clear about this issue is that a lack of clarity leads to problems in relation to taking leave, and in relation to attendance at college.

Attendance at lectures

As above, you are being paid to attend college, and hence attendance is a requirement of your employment contract (in other words, you cannot choose whether to come to lectures).

If you are unable to attend college, you must notify your Course Tutor (via email) and the Placements Coordinator (via Microsoft Forms - https://forms.office.com/e/1xXPKe31DP) as early in the morning as is practicable , indicating the reason for your absence. Appropriate reasons for absence are the usual and obvious ones, such as illness, urgent medical consultations that cannot be scheduled for any other time, or unforeseen crises. (If you are unable to attend on a placement day, you must notify your Course Tutor and the Placements Coordinator (via Microsoft Forms - https://forms.office.com/e/1xXPKe31DP) and your supervisor(s) and anyone else on placement who needs to know.)

In cases where trainees do not attend college and do not contact us within a reasonable period, we will report this absence to the employing Trust.

Persistent failure to attend lectures without good reason will be investigated, and could render a trainee subject to a learning agreement and disciplinary action.

Taking leave during academic terms

During academic terms trainees cannot take periods of leave that include days when lectures take place. This does not mean that trainees cannot take any breaks during term-time – there is no bar on taking leave on placement days.

Exceptions to this rule: There will be occasions when trainees have a legitimate reason for wishing to be absent on academic days. For example, they may have been given a time to attend for medical treatment on an academic day which is difficult to reschedule, or they may be acting in a caring role for an individual who requires medical intervention. Sometimes there are significant (as opposed to routine) social occasions that a trainee wishes to attend– for example, family weddings, funerals, or special events involving partners. In all such cases trainees should talk to their Course Tutor *before* arranging any leave. Since we are responsive to reasonable requests, we expect trainees to discuss any requests for exceptional leave arrangements in advance. Your Course Tutor will inform you whether your request for exceptional leave has been granted.

It is inappropriate to request leave retrospectively, and especially inappropriate if the request is made after making travel arrangements (for example, after purchasing tickets), since this can be presented as a *fait accompli*. It is within the course's rights to refuse leave, even where this would involve some financial loss.

LEAVE ENTITLEMENTS

Annual leave

Basic entitlements

Trainees have 27 days of annual leave per annum. Because the leave year runs from 1st April, first year trainees have 14 days leave from when they start to the end of March. In their final year, third year trainees have 14 days from the 1st April to the end of September (when they complete the course).

Long service leave entitlement

Trainees who have been working in the NHS for a given amount of time are entitled to increased annual leave entitlement:

- with 5 years' continuous service: 29 days (15 days in the first/last leave year of the course)
- with 10 years' continuous service: 33 days (16 days in the first/last year of the course)

If the entitlement to additional leave starts part-way through the leave year then this will be added pro rata for the leave year (it will become effective from the first month following the date of the increased entitlement).

If you think you are eligible for long service leave, please email Camden & Islington HR (beh-tr.peoplehubnlmhp@nhs.net). They will be able to tell you what evidence is required and will confirm if your annual leave entitlement has increased). Trainees are then responsible for notifying both the Clinical Placements Coordinator and the relevant year group line manager of such increase, and providing them with the evidence received via C&I HR. The trainee should also upload this evidence as an additional file to the Personnel File area of the ETFS.

Carry-over of leave

You can carry over up to 5 days of leave from one leave-year to the next. If you have more than 5 days of leave to take at the end of the leave year, you will lose it. We strongly recommend that you take all your leave in each leave year, because the more leave you carry over, the less likely it is that you will take it. **This advice is especially important as you come to the end of training, because you cannot carry-over over any leave at the end of the course. This means that any leave owing at the end of the course is 'lost'.**

Restrictions on leave and tips on taking leave

Trainees are strongly recommended to plan ahead to ensure that they take their leave. This may seem an odd suggestion, but pressures of work are such that trainees sometimes realise – too late – that they have more leave to take than they can use.

Because of its impact on planning of clinical work, supervisors must be given as much warning as possible about any plans for leave. It is expected that trainees will identify, and be prepared to negotiate, leave arrangements with their supervisors as early as possible in the placement – including any special leave arrangements such as religious holidays, etc.

As far as possible, trainees should plan to take broadly equal amounts of leave in each placement, because taking only a few days in one placement means that the burden of leave falls to the next placement

Taking a block of about 2 weeks continuous leave does not require any special permission (though as above, supervisor should have good notice of any plans for leave). However:

a) taking a block of more than 2 weeks continuous leave in one placement may cause disruption to clinical work. For this reason taking longer periods of leave (especially anything over 3 weeks continuous leave) need to be negotiated carefully, in advance, with supervisors.

b) long periods of continuous leave (for example, around 4 weeks) may not be possible if it would cause significant disruption to clinical work. However, there may be good reasons why this length of leave is requested, and there should be prior negotiation with supervisors (in the first instance) and with your course tutor.

As described above, leave cannot be taken during academic terms if this results in missing lectures.

Sick leave
Arrangements for single episodes of sick leave follow standard employment practice:

- If you are unable to attend placement, you should notify your supervisor as soon as possible – normally on the first day of any sick leave. At the start of each placement it is a good idea to identify the person to contact who can notify anyone who will be affected by your absence. Please note that the college should also be informed of any absence from placement so it can be noted on your attendance record accordingly. Therefore, when declaring a need for sick leave from placement, you also need to inform your Course Tutor (via email) and the Placement Coordinator (via Microsoft Forms - https://forms.office.com/e/1xXPKe31DP).
- For absences of 8 calendar days or more you must submit a medical certificate ('fit note') from a GP or appropriate healthcare professional promptly within 5 working days of the 8th calendar day of absence. Bear in mind that you should include weekends in this count (it is not a count of working days off, but of total days of continuous illness).

You should alert your supervisor/placement and the college of any illness as soon as is practicable.

It is important to signal that Camden and Islington's 'Managing attendance and absence policy and procedure' indicates that multiple brief episodes of sick leave can trigger an investigation to ensure that trainees are fit for work. This can include an appointment with Occupational Health as well as a formal meeting with the Line Manager.

Leave for exceptional circumstances
Bereavement leave, leave for urgent domestic distress and carer leave are all designed to allow trainees to manage various forms of personal crises, and are described below. As far as possible trainees should alert relevant parties to the need for leave, but they should use their discretion if they have to leave work at short notice in order to deal with a crisis. In such cases they should follow the arrangements for sick leave (which means contacting supervisors and the college as soon as possible, informing them of the situation and requesting special leave and authorisation to leave work or college).

Bereavement leave
Bereavement leave is paid leave which is given when a member of the employee's immediate family (or someone who has acted in the role of a member of the employee's immediate family) dies. 'Immediate family' in terms of the C&I policy means a parent, spouse, partner or civil partner, or children. This list is not exhaustive and there may be other relationships where the person has been a member of the employee's immediate family.

As soon as is practicable you should contact your course tutor (cc'ing your relevant year group line manager) to discuss claiming bereavement leave. In the event of the death of a spouse/partner or parent up to 5 working days leave may be granted. Bereavement leave granted does not need to be taken as consecutive days, the bereavement leave granted will include the time needed to attend the close relative's funeral. The trust has special provisions in circumstances where parents experience the death of a child.

Attendance at any other funeral (other than that of a member of immediate family or other relative) may be requested as unpaid time or annual leave.

Leave for “Urgent Domestic Distress”
Trainees can request leave in order to deal with urgent domestic emergencies, such as burglary, fire or flooding. You can normally be granted 1 day of paid special leave. If the need for time off continues other options may need to be considered such as annual leave, flexible working or unpaid leave.

Time off for dependants (carer’s leave)
This form of leave can be requested to provide support to deal with unexpected or sudden family emergencies. This leave cannot be booked in advance as it’s provided in case of emergencies. In usual circumstances, one day’s carer’s leave is granted but depending on circumstances up to 5 working days can be granted to cover a single episode in any 12 month period in discussion with your course tutor and your relevant year group line manager.

Carer’s leave will not apply to care being provided by a hospital or accompanying dependants to planned medical or dental appointments. These need to be taken as annual leave or unpaid leave as appropriate.

Employees who have been employed for a minimum NHS continuous period of 12 months at the time the leave is requested may apply for extended unpaid special leave.

Maternity leave
Entitlement to maternity leave and benefits varies in relation to the length of time you have been on the course or in NHS employment. As a first step, you should consult C&I’s Family Friendly Leave Policy in order to understand your entitlements and what information you will need to provide when. You should also discuss with your course tutor who will be able to help you make plans and who formally records your absence from the course, and ultimately with your relevant year group line manager. Detailed requests for advice and paperwork should be directed at Camden and Islington Human Resources.

Paternity Leave
Paternity leave applies to biological and adoptive fathers, husband, wife or partner of the mother. Eligible employees are entitled to up to two weeks paid leave and reasonable time off to attend ante-natal classes. In order to take this leave you will need to submit the Paternity Leave Application Form (Form PL1), signed by your relevant year group line manager, to C&I at least 28 days before the requested start date. Please consult C&I’s Family Friendly Leave Policy for eligibility criteria.

Shared Parental leave
Please consult C&I’s Family Friendly Leave Policy for further details.

Keeping in Touch (KIT) days
Employees on maternity/parental leave are entitled to up to a maximum of 10 KIT days – these are intended to help employees maintain contact with their work context, and may be paid in certain agreed circumstances.

The idea of ‘keeping in touch’ is worth clarifying. In the context of the DClinPsy programme, the main focus is on facilitating the transition from maternity leave back into work; as such the usual reason for claiming a KIT day would be to undertake planning or preparation relevant to a return to the programme.

Examples could include a trainee:

- meeting with the placement supervisor with whom they will be working on their return to work;
- undertaking a placement-specific training day (e.g. Ri0, PC-MIS, safety procedures) that they would otherwise miss;
- meeting with course staff to discuss and to plan assignments that will be undertaken on the trainee’s return to work (e.g. meeting a research supervisor or course tutor, usually where advance planning is needed in order to aid the transition back into the programme)

- attending a unique training event that will not be repeated (for example, a lecture that will not be repeated after their return to college, or a "one-off" conference that the programme has organised)
- attending teaching that directly supports a return to work, where missing teaching could have an adverse impact (for example, a session advising on procedures for the research viva)
- undertaking "extra-ordinary" academic work that cannot be delayed until the trainee returns to work, and where delay would make it likely that a further extension to training would be required (e.g. revising an ethics application that needs to be approved in order for research to start as soon as the trainee returns to work).

These examples are illustrative, and cases will be dealt with on an individual basis.

KIT days cannot be used by a trainee to participate in 'routine' teaching or training events nor can they be used to 'catch-up' with academic, clinical or research assignments that would be expected to be undertaken after returning to work (for example, writing a case report or sections of the research thesis).

The approval of KIT days is at the discretion of your relevant year group line manager, to whom the relevant application form should be submitted by trainees wishing to take a KIT day.

Religious/ cultural observance
Trainees who wish to take days for religious observance, or who wish to have an earlier finishing time can request this, and (in general) can expect some flexibility – the usual expectation is that supervisors and the course will try to accommodate these requests. However, there is no specific leave entitlement to cover such arrangements, which need to be taken as annual leave, unpaid leave, or by making up any time lost. It is also important that trainees discuss any such requests at the start of the placement, and give good notice of any intended leave.

Disability Leave
Disability leave is time off from work for a reason related to someone's disability or long term condition, a condition which lasts 12 months or more. It is a type of reasonable adjustment/workplace adjustment which employees are entitled to under the Equality Act (2010). Employees can take up to 10 working days of short term disability leave per rolling 12 month period. If a longer period is required, a trainee should speak to their line manager. If time off work due to ill health is for a reason not related to a disability/long term condition, then it should be recorded as sickness absence.

Research Study Leave
At certain points in the research cycle trainees may need to work more intensively on their thesis research project. For this reason (from the beginning of the second year of the course onwards) trainees can apply to take up to 6 days of Research Study Leave from each six-month placement, in order to focus on their research.

There is no automatic entitlement to this leave - trainees should negotiate research study leave with their Clinical Supervisor preferably well in advance. Such requests must be carefully balanced with placement demands. Leave can be taken as a single block or as a series of days over a period of time, with the number of days taken reflecting need.

Examples of times a trainee might take study leave could include:

- A trainee who wishes to work on the literature review over successive days in order that they can maintain the flow of their ideas
- A trainee whose research is predicated on attending clinical meetings which are always scheduled for a placement day, and who therefore needs to take days of research study leave over a period of time in order to attend the meetings
- A trainee who needs to attend a research ethics committee

• A trainee whose data-collection is best achieved using a block of time, or who needs to schedule data-collection around hard-to-book lab times

As should be clear from the above examples, decisions about taking research study leave as a block or as a series of days will depend on the need the leave is addressing.

Procedure

a) Trainees should ensure that if they are taking Research Study Leave they will have undertaken enough days on placement to meet the BPS criteria, as indicated in the Training Handbook.

b) In the first instance applications for research leave must be negotiated with the Clinical Supervisor, either early in the placement, or as soon as the need for leave becomes clear. Clinical supervisors are entitled to balance the needs of the clinical placement against the trainee's need to undertake research. This means that trainees may have to take fewer than six days study time, or even no study time at all. On occasion it may be that Research Study Leave is requested later in the placement (for example if there have been unforeseen difficulties with recruitment and the study time is required to manage this).

c) If the clinical supervisor is agreeable to the leave being taken, trainees need to deduct this from their number of placement days.

Additional information for international students
Tier 4 monitoring arrangements

For those trainees who are being sponsored by UCL on a Tier 4 Visa, UCL is required to monitor academic engagement throughout the year. Officially, there are 11 monitoring time points, and lack of engagement can have serious consequences for your continued enrolment.

As with home/EU students, leave should not be taken during the designated teaching and examination periods. If you require an authorised absence (sick leave and exceptional circumstances listed above) for more than two weeks during the academic programme, this needs to be approved by the relevant year group line manager. Such requests for leave of more than two weeks should be made prior to arranging your travel as the department is required to first notify the UCL Visa Compliance team of such requests. These requests should be made through Sharinjeet Dhiman, International Trainee Administrator.

Under Tier 4 visa arrangements, it is your responsibility to keep your contact details up to date on Portico. This includes, address, mobile phone number and email address. UK visa and immigration requirements change frequently and therefore, you are advised to check the UK Visa and Immigration website for the most up-to-date information.

RECORDING LEAVE AND SICKNESS ABSENCE

Trainees should notify any absence to the Course. As above, arrangements for leave cover the ‘working week’, and hence must include any absence **from placement or from college**, and include:

- any annual leave
- any sick leave
- any other absence (for example, bereavement leave)

Trainee absence/leave is recorded on the Annual Leave area of the ETFS. Trainees are responsible for adding their own annual leave, once approved by the relevant parties, onto the system directly; sick leave and any other types of absence need to be reported to the Clinical Placement Coordinator (via Microsoft Forms: https://forms.office.com/e/1xXPKe31DP, after you’ve informed your Course Tutor and placement (where appropriate).

Trainee attendance figures are shared with Camden and Islington NHS Trust, and are a formal record of your pattern of leave. On this basis, failing to record leave accurately is potentially a disciplinary matter.

CALCULATING ANNUAL LEAVE ENTITLEMENT

Calculating annual leave is usually fairly straightforward, but it can be complicated by study time and research time entitlements, and by shifting patterns of work in and out of term-time (see Section 10).

The problem

When calculating how much annual leave they have taken, some trainees inappropriately deduct study days and study time from their calculations. This has the effect of reducing the amount of annual leave they claim, and hence gives them more leave than they are entitled to.

How the problem arises

As above, and at the risk of repetition, you are paid to work 5 days a week. This means that you are paid for everything you do during the working week – for clinical days, for academic days, for study days, for research, and so on.

Past experience tells us that trainees slip into the habit of treating only placement days as coming under employment regulations, and treating days in college or study/research days as if student status applies – in other words, they forget that employment regulations apply to everything.

It doesn't help that study and research time is often called study leave rather than study or research time. As described in Section 10, it is not leave:
a) it is time made available for study or research, in recognition of the other duties a trainee is expected to carry out
b) it is acquired on the basis that a trainee is available for work in any particular week. If a trainee takes time off during a week, this will reduce the amount of clinical or study time they are entitled to, in proportion to the amount of time they are working.

The consequence

Example 1

Consider a trainee taking annual leave out of term.

- Assume that they normally work 4 days on placement and 1 study day
- They take 5 days off (Monday through to Friday)

- The correct return is 5 days of annual leave. This is for a simple reason – the study day is not a leave day – it is a day for which trainees are paid, like any other.
- The trainee might (in error) return this as 4 days of annual leave. This happens if they treat the study day as if it wasn't a day of employment

Example 2

Here the trainee in Example 1 takes 4 days of annual leave (Monday through to Thursday) and studies on the fifth day.

The correct return is still 5 days of annual leave. This is because the study day in any one week needs to be 'earned', on the basis that the trainee is working during that week. Remember that study time is there in recognition of the other duties trainees need to perform. It is a *notional* day, not a fixed entitlement. If the trainee isn't working during the week, there is no study day.

Further examples – the weekly pattern is notional; shaded days show days taken as leave

Monday	Tuesday	Wednesday	Thursday	Friday
Placement	placement	college	placement	study day

= 1 day of annual leave

Monday	Tuesday	Wednesday	Thursday	Friday
Placement	placement	college	placement	study day

= 4 days of annual leave

Out of term (where there are 4 placement days a week)

Monday	Tuesday	Wednesday	Thursday	Friday
Placement	placement	placement	placement	study day

= 5 days of annual leave

Monday	Tuesday	Wednesday	Thursday	Friday
Placement	placement	placement	placement	study day

= 3 days of annual leave

Monday	Tuesday	Wednesday	Thursday	Friday
Placement	placement	placement	placement	study day

= 5 days of annual leave

This can all get rather complicated, and there is a limit to how many examples we can give. If in doubt, ask your course tutor.

ATTENDING CONFERENCES AND COURSE FUNDING FOR CONFERENCES

From time to time trainees may wish to attend a conference or meeting. However:

a) attending teaching at college takes precedence over a conference.
b) if the conference takes place over placement days, attendance should be discussed with supervisors in the first instance as well as your Course Tutor, and may involve taking annual leave. Clearly if a conference/meeting is recommended by a supervisor and takes place as part of placement activity, this caution on attendance does not apply.

Because our purchasers make the assumption that the course covers trainees' academic education, we do not have any funding for attendance at outside seminars or conferences.

health & care professions council

Standards of proficiency

Practitioner psychologists

Contents

Foreword

We are pleased to present the Health and Care Professions Council's (HCPC) standards of proficiency for practitioner psychologists.

We first published standards of proficiency for practitioner psychologists in July 2009. We made minor changes to the standards following publication in October 2010. We review the standards regularly to look at how they are working and to check whether they continue to reflect current practice in the professions we regulate.

These new revised standards are a result of our most recent review of the standards of proficiency. As a result of the first stage of the review, and the results of a public consultation, we have revised our generic standards which apply to all the professions we regulate. The revised standards are now based around 15 generic statements. This new structure means that we can retain the standards which are shared across all the professions we regulate, whilst allowing us more flexibility in describing the detailed standards which are specific to individual professions.

The profession-specific standards for practitioner psychologists included in this document were developed through the input of the relevant professional bodies and the views of all stakeholders during a further public consultation. The review process and consultation produced valuable feedback and we are grateful to all those who gave their time to help us in shaping the new standards.

We have made a small number of changes to the standards overall, mainly to reflect developments in education and practice, to clarify our intentions and to correct any errors or omissions. We have also made some minor changes to the introduction, in particular to explain the language we use in the standards.

We are confident that the standards are fit for purpose and reflect safe and effective professional practice for practitioner psychologists.

These standards are effective from Wednesday 1 July 2015.

Introduction

This document sets out the standards of proficiency. These standards set out safe and effective practice in the professions we regulate. They are the threshold standards we consider necessary to protect members of the public. They set out what a student must know, understand and be able to do by the time they have completed their training, so that they are able to register with us. Once on our Register you must meet those standards of proficiency which relate to the areas in which you work.

We also expect you to keep to our standards of conduct, performance and ethics and standards for continuing professional development. We publish these in separate documents, which you can find on our website.

In the practitioner psychologist part of our Register, there are seven distinct domains. The standards of proficiency in this document include both generic elements, which apply to all our registrants, profession-specific elements which are relevant to all practitioner psychologists and domain-specific standards which apply to a particular domain. The generic standards are written in **bold**, the profession-specific standards are written in plain text, with the domain-specific standards written in plain blue text.

We have numbered the standards so that you can refer to them more easily. The standards are not hierarchical and are all equally important for practice.

A note about our expectations of you

You must meet all the standards of proficiency to register with us and meet the standards relevant to your scope of practice to stay registered with us.

It is important that you read and understand this document. If your practice is called into question we will consider these standards (and our standards of conduct, performance and ethics) in deciding what action, if any, we need to take.

The standards set out in this document complement information and guidance issued by other organisations, such as your professional body or your employer. We recognise the valuable role played by professional bodies in providing guidance and advice about good practice which can help you to meet the standards in this document.

Your scope of practice

Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself.

We recognise that a registrant's scope of practice will change over time and that the practice of experienced registrants often becomes more focused and specialised than that of newly registered colleagues. This might be because of specialisation in a certain area or with a particular client group, or a movement into roles in management, education or research. Every time you renew your registration, you will be asked to sign a declaration that you continue to meet the standards of proficiency that apply to your scope of practice.

Your particular scope of practice may mean that you are unable to continue to demonstrate that you meet all of the standards that apply for the whole of your profession. As long as you make sure that you are practising safely and effectively within your given scope of practice and do not practise in the areas where you are not proficient to do so, this will not be a problem. If you want to move outside of your scope of practice, you should be certain that you are capable of working lawfully, safely and effectively. This means that you need to exercise personal judgement by undertaking any necessary training and experience, before moving into a new area of practice.

Meeting the standards

It is important that you meet our standards and are able to practise lawfully, safely and effectively. However, we do not dictate how you should meet our standards. There is normally more than one way in which each standard can be met and the way in which you meet our standards might change over time because of improvements in technology or changes in your practice.

We often receive questions from registrants who are concerned that something they have been asked to do, a policy, or the way in which they work might mean they cannot meet our standards. They are often worried that this might have an effect on their registration.

As an autonomous professional, you need to make informed, reasoned decisions about your practice to ensure that you meet the standards that apply to you. This includes seeking advice and support from education providers, employers, colleagues, professional bodies, unions and others to ensure that the wellbeing of service users is safeguarded at all times. So long as you do this and can justify your decisions if asked to, it is very unlikely that you will not meet our standards.

Language

We recognise that our registrants work in a range of different settings, which include clinical practice, education, research and roles in industry. We also recognise that the use of terminology can be an emotive issue.

Our registrants work with very different people and use different terms to describe the groups that use, or are affected by, their services. Some of our registrants work with patients, some with clients which can include organisations, and others with service users. We have used the term ‘service user’ in a broad sense in the standards to refer to anyone who uses or is affected by the services of our registrants. However, the term you use to describe the groups that use, or are affected by, the services you offer will be guided by context and the area or domain you practise in.

When we consulted on the standards we received a lot of different feedback about our use of the terms 'evidence-based' and 'evidence-informed' but with no clear consensus on which of these terms were preferred. These terms are about practitioner psychologists’ awareness and use of research and other evidence, where this is available, to guide their practice. As a result, in standard 12.1, which applies to all practitioner psychologists and is about use of evidence more generally, we have used both terms. In the other standards which apply to specific psychological models or frameworks, we have retained our existing terminology of 'evidence-based'.

In the standards of proficiency, we use phrases such as ‘understand’, ‘know’, and ‘be able to’. This is so the standards remain applicable to current registrants in maintaining their fitness to practise, as well as prospective registrants who have not yet started practising and are applying for registration for the first time.

These standards may change in the future

We have produced these standards after speaking to our stakeholders and holding a formal public consultation.

We will continue to listen to our stakeholders and will keep our standards under continual review. Therefore, we may make further changes in the future to take into account changes in practice.

We will always publicise any changes to the standards that we make by, for instance, publishing notices on our website and informing professional bodies.

Standards of proficiency

Registrant practitioner psychologists must:

1 be able to practise safely and effectively within their scope of practice

1.1 know the limits of their practice and when to seek advice or refer to another professional

1.2 recognise the need to manage their own workload and resources effectively and be able to practise accordingly

2 be able to practise within the legal and ethical boundaries of their profession

2.1 understand the need to act in the best interests of service users at all times

2.2 understand what is required of them by the Health and Care Professions Council

2.3 understand the need to respect and uphold the rights, dignity, values and autonomy of service users including their role in the assessment, treatment and intervention process and in maintaining health and wellbeing

2.4 recognise that relationships with service users should be based on mutual respect and trust, and be able to maintain high standards of practice even in situations of personal incompatibility

2.5 understand current legislation applicable to the work of their profession

2.6 understand the importance of and be able to obtain informed consent

2.7 be able to exercise a professional duty of care

2.8 understand the complex ethical and legal issues of any form of dual relationship and the impact these may have on service users

2.9 understand the power imbalance between practitioners and service users and how this can be managed appropriately

2.10 be able to recognise appropriate boundaries and understand the dynamics of power relationships

2.11 understand the organisational context for their practice as a practitioner psychologist

3 be able to maintain fitness to practise

3.1 understand the need to maintain high standards of personal and professional conduct

3.2 understand the importance of maintaining their own health

3.3 understand both the need to keep skills and knowledge up to date and the importance of career-long learning

3.4 be able to manage the physical, psychological and emotional impact of their practice

4 be able to practise as an autonomous professional, exercising their own professional judgement

4.1 be able to assess a professional situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with the problem

4.2 be able to make reasoned decisions to initiate, continue, modify or cease treatment, intervention or the use of techniques or procedures, and record the decisions and reasoning appropriately

4.3 be able to initiate resolution of problems and be able to exercise personal initiative

4.4 recognise that they are personally responsible for and must be able to justify their decisions

4.5 be able to make and receive appropriate referrals

4.6 understand the importance of participation in training, supervision and mentoring

5 be aware of the impact of culture, equality and diversity on practice

5.1 understand the impact of differences such as gender, sexuality, ethnicity, culture, religion and age on psychological wellbeing or behaviour

5.2 understand the requirement to adapt practice to meet the needs of different groups and individuals

6 be able to practise in a non-discriminatory manner

7 understand the importance of and be able to maintain confidentiality

7.1 be aware of the limits of the concept of confidentiality

7.2 understand the principles of information governance and be aware of the safe and effective use of health, social care and other relevant information

7.3 be able to recognise and respond appropriately to situations where it is necessary to share information to safeguard service users or the wider public

8 be able to communicate effectively

8.1 be able to demonstrate effective and appropriate verbal and non-verbal skills in communicating information, advice, instruction and professional opinion to service users, colleagues and others

8.2 be able to communicate in English to the standard equivalent to level 7 of the International English Language Testing System, with no element below 6.5[1]

8.3 understand how communication skills affect assessment of, and engagement with, service users and how the means of communication should be modified to address and take account of factors such as age, capacity, learning ability and physical ability

8.4 be able to select, move between and use appropriate forms of verbal and non-verbal communication with service users and others

8.5 be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs

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[1] The International English Language Testing System (IELTS) tests competence in the English language. Applicants who have qualified outside of the UK, whose first language is not English and who are not nationals of a country within the European Economic Area (EEA) or Switzerland, must provide evidence that they have reached the necessary standard. Please visit our website for more information.

8.6 understand the need to provide service users or people acting on their behalf with the information necessary to enable them to make informed decisions

8.7 be able to select the appropriate means for communicating feedback to service users

8.8 be able to provide psychological opinion and advice in formal settings, as appropriate

8.9 be able to communicate ideas and conclusions clearly and effectively to specialist and non-specialist audiences

8.10 be able to explain the nature and purpose of specific psychological techniques to service users

8.11 be able to summarise and present complex ideas in an appropriate form

8.12 understand the need to assist the communication needs of service users such as through the use of an appropriate interpreter, wherever possible

8.13 recognise the need to use interpersonal skills to encourage the active participation of service users

8.14 be able to use formulations to assist multi-professional communication and understanding

8.15 understand explicit and implicit communications in a practitioner – service user relationship

8.16 be able to appropriately define and contract work with commissioning service users or their representatives

Counselling psychologists only

8.17 understand how empathic understanding can be helped by creativity and artistry in the use of language and metaphor

9 be able to work appropriately with others

9.1 be able to work, where appropriate, in partnership with service users, other professionals, support staff and others

9.2 understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team

9.3 understand the need to engage service users and carers in planning and evaluating assessments, treatments and interventions to meet their needs and goals

9.4 understand the need to implement interventions, care plans or management plans in partnership with service users, other professionals and carers

9.5 be able to initiate, develop and end a practitioner – service user relationship

9.6 understand the dynamics present in relationships between service users and practitioners

9.7 be able to contribute effectively to work undertaken as part of a multi-disciplinary team

9.8 be able to plan, design and deliver teaching and training which takes into account the needs and goals of participants

9.9 be able to support the learning of others in the application of psychological skills, knowledge, practices and procedures

9.10 be able to use psychological formulations with service users to facilitate their understanding of their experience or situation

10 be able to maintain records appropriately

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines

10.2 recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines

11 be able to reflect on and review practice

11.1 understand the value of reflection on practice and the need to record the outcome of such reflection

11.2 recognise the value of case conferences or other methods of review

11.3 be able to reflect critically on their practice and consider alternative ways of working

11.4 understand models of supervision and their contribution to practice

Counselling psychologists only

11.5 be able to critically reflect on the use of self in the therapeutic process

12 be able to assure the quality of their practice

12.1 be able to engage in evidence-based and evidence-informed practice, evaluate practice systematically and participate in audit procedures

12.2 be able to gather information, including qualitative and quantitative data, that helps to evaluate the responses of service users to their care or experience

12.3 be aware of the role of audit and review in quality management, including quality control, quality assurance and the use of appropriate outcome measures

12.4 be able to maintain an effective audit trail and work towards continual improvement

12.5 be aware of, and able to participate in, quality assurance programmes, where appropriate

12.6 be able to evaluate intervention plans using recognised outcome measures and revise the plans as necessary in conjunction with the service user

12.7 be able to revise formulations in the light of ongoing intervention and when necessary reformulate the problem

12.8 recognise the need to monitor and evaluate the quality of practice and the value of contributing to the generation of data for quality assurance and improvement programmes

12.9 be able to monitor agreements and practices with service users, groups and organisations

13 understand the key concepts of the knowledge base relevant to their profession

13.1 understand the structure and function of the human body, together with knowledge of health, well-being, disease, disorder and dysfunction relevant to their domain

13.2 be aware of the principles and applications of scientific enquiry, including the evaluation of the effectiveness of interventions and the research process

13.3 recognise the role of other professions and stakeholders relevant to the work of their domain

13.4 understand the structures and functions of UK service providers applicable to the work of their domain

13.5 understand the theoretical basis of, and the variety of approaches to, assessment and intervention

13.6 understand the role of the practitioner psychologist across a range of settings and services

13.7 understand the concept of leadership and its application to practice

13.8 understand the application of consultation models to service-delivery and practice, including the role of leadership and group processes

Clinical psychologists only

13.9 understand theories and evidence concerning psychological development and psychological difficulties across the lifespan and their assessment and remediation

13.10 understand more than one evidence-based model of formal psychological therapy

13.11 understand psychological models related to how biological, sociological and circumstantial or life-event-related factors impinge on psychological processes to affect psychological wellbeing

13.12 understand psychological models related to a range of presentations including:

- service users with presentations from acute to enduring and mild to severe;
- problems with biological or neuropsychological aspects; and
- problems with mainly psychosocial factors including problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic physical and mental health conditions

13.13 understand psychological models related to service users:

- from a range of social and cultural backgrounds;
- of all ages;
- across a range of intellectual functioning;
- with significant levels of challenging behaviour;
- with developmental learning disabilities and cognitive impairment;
- with communication difficulties;
- with substance misuse problems; and
- with physical health problems

13.14 understand psychological models related to working:

- with service users, couples, families, carers, groups and at the organisational and community level; and
- in a variety of settings including in-patient or other residential facilities with high-dependency needs, secondary health care and community or primary care

13.15 understand change and transition processes at the individual, group and organisational level

13.16 understand social approaches such as those informed by community, critical and social constructivist perspectives

13.17 understand the impact of psychopharmacological and other clinical interventions on psychological work with service users

Counselling psychologists only

13.18 understand the philosophical bases which underpin those psychological theories which are relevant to counselling psychology

13.19 understand the philosophy, theory and practice of more than one evidence-based model of formal psychological therapy

13.20 understand psychological models related to a range of presentations including:

- service users with presentations from acute to enduring and mild to severe;
- problems with biological or neuropsychological aspects; and
- problems with mainly psychosocial factors including problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic physical and mental health conditions

13.21 understand the therapeutic relationship and alliance as conceptualised by each model

13.22 understand the spiritual and cultural traditions relevant to counselling psychology

13.23 understand the primary philosophical paradigms that inform psychological theory with particular regard to their relevance to, and impact upon, the understanding of the subjectivity and inter-subjectivity of experience throughout human development

13.24 understand theories of human cognitive, emotional, behavioural, social and physiological functioning relevant to counselling psychology

13.25 understand different theories of lifespan development

13.26 understand social and cultural contexts and the nature of relationships throughout the lifespan

13.27 understand theories of psychopathology and of change

13.28 understand the impact of psychopharmacology and other interventions on psychological work with service users

Educational psychologists only

13.29 understand the role of the educational psychologist across a range of school and community settings and services

13.30 understand the educational and emotional factors that facilitate or impede the provision of effective teaching and learning

13.31 understand psychological theories of, and research evidence in, child, adolescent and young adult development relevant to educational psychology

13.32 understand the structures and systems of a wide range of settings in which education, health and care are delivered for children, adolescents and young adults, including child protection procedures

13.33 understand psychological models related to the influence of school ethos and culture, educational curricula, communication systems, management and leadership styles on the cognitive, behavioural, emotional and social development of children, adolescents and young adults

13.34 understand psychological models of the factors that lead to underachievement, disaffection and social exclusion amongst vulnerable groups

13.35 understand theories and evidence underlying psychological intervention with children, adolescents, young adults, their parents or carers, and education and other professionals

13.36 understand psychological models related to the influence on development of children, adolescents and young adults from:

- family structures and processes;
- cultural and community contexts; and
- organisations and systems

13.37 understand change and transition processes at the individual, group and organisational level

13.38 understand the theoretical basis of, and the variety of approaches to, consultation and assessment in educational psychology

Forensic psychologists only

13.39 understand the application of psychology in the legal system

13.40 understand the application and integration of a range of theoretical perspectives on socially and individually damaging behaviours, including psychological, social and biological perspectives

13.41 understand psychological models related to a range of presentations including:

- service users with presentations from acute to enduring and mild to severe;
- problems with biological or neuropsychological aspects; and
- problems with mainly psychosocial factors including problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic physical and mental health conditions

13.42 understand psychological theories and their application to the provision of psychological therapies that focus on offenders and victims of offences

13.43 understand effective assessment approaches with service users presenting with individually or socially damaging behaviour

13.44 understand the development of criminal and antisocial behaviour

13.45 understand the psychological interventions related to different service user groups including victims of offences, offenders, litigants, appellants and individuals seeking arbitration and mediation

Health psychologists only

13.46 understand context and perspectives in health psychology

13.47 understand the epidemiology of health and illness

13.48 understand:

- biological mechanisms of health and disease;
- health-related cognitions and behaviour;
- stress, health and illness;
- individual differences in health and illness;
- lifespan, gender and cross-cultural perspectives; and
- long-term conditions and disability

13.49 understand applications of health psychology and professional issues

13.50 understand healthcare in professional settings

Occupational psychologists only

13.51 understand the following in occupational psychology:

- human-machine interaction;
- design of environments and work;
- personnel selection and assessment;
- performance appraisal and career development;
- counselling and personal development;
- training;
- employee relations and motivation; and
- organisational development and change

Sport and exercise psychology

13.52 understand cognitive processes, including motor skills, practice skills, learning and perception; and self-regulation

13.53 understand psychological skills such as:

- goal setting;
- self-talk;
- imagery;
- pre-performance routines;
- arousal control, such as relaxation and activation; and
- strategies for stress and emotion management

13.54 understand exercise and physical activity including:

- determinants, such as motives, barriers and adherence;
- outcomes in relation to affect, such as mood and emotion;
- cognition and mental health issues, such as self-esteem, eating disorders, depression and exercise dependence;
- lifestyle and quality of life; and
- injury

13.55 understand individual differences including:

- mental toughness, hardiness and resilience;
- personality;
- confidence;
- motivation;
- self-concept and self-esteem; and
- stress and coping

13.56 understand social processes within sport and exercise psychology including:

- interpersonal skills and relationships;
- group dynamics and functioning;
- organisational issues; and
- leadership

13.57 understand the impact of developmental processes, including lifespan issues and processes related to career transitions and termination

14 be able to draw on appropriate knowledge and skills to inform practice

14.1 be able to apply psychology across a variety of different contexts using a range of evidence-based and theoretical models, frameworks and psychological paradigms

14.2 be able to change their practice as needed to take account of new developments or changing contexts

14.3 be able to conduct appropriate assessment or monitoring procedures, treatment, interventions, therapy or other actions safely and effectively

14.4 be able to conduct consultancy

14.5 be able to formulate specific and appropriate management plans including the setting of timescales

14.6 be able to manage resources to meet timescales and agreed project objectives

14.7 be able to use psychological formulations to plan appropriate interventions that take the service user’s perspective into account

14.8 be able to direct the implementation of applications and interventions carried out by others

14.9 be able to gather appropriate information

14.10 be able to make informed judgements on complex issues in the absence of complete information

14.11 be able to work effectively whilst holding alternative competing explanations in mind

14.12 be able to generalise and synthesise prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations

14.13 be able to select and use appropriate assessment techniques

14.14 be able to undertake and record a thorough, sensitive and detailed assessment, using appropriate techniques and equipment

14.15 be able to choose and use a broad range of psychological assessment methods, appropriate to the service user, environment and the type of intervention likely to be required

14.16 be able to decide how to assess, formulate and intervene psychologically from a range of possible models and modes of intervention with service users or service systems

14.17 be able to use formal assessment procedures, systematic interviewing procedures and other structured methods of assessment relevant to their domain

14.18 be able to undertake or arrange investigations as appropriate

14.19 be able to analyse and critically evaluate the information collected

14.20 be able to critically evaluate risks and their implications

14.21 be able to demonstrate a logical and systematic approach to problem solving

14.22 be able to use research, reasoning and problem solving skills to determine appropriate actions

14.23 be able to recognise when further intervention is inappropriate, or unlikely to be helpful

14.24 recognise the value of research to the critical evaluation of practice

14.25 be aware of a range of research methodologies

14.26 be able to evaluate research and other evidence to inform their own practice

14.27 be able to initiate, design, develop, conduct and critically evaluate psychological research

14.28 understand a variety of research designs

14.29 be able to understand and use applicable techniques for research and academic enquiry, including qualitative and quantitative approaches

14.30 be able to use professional and research skills in work with service users based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation

14.31 understand research ethics and be able to apply them

14.32 be able to conduct service and large scale evaluations

14.33 be able to use information and communication technologies appropriate to their practice

Clinical psychologists only

14.34 be able to assess social context and organisational characteristics

14.35 be able to develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models

14.36 be able to draw on knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities

14.37 understand therapeutic techniques and processes as applied when working with a range of individuals in distress including:

- those who experience difficulties related to anxiety, mood, adjustment to adverse circumstances or life-events, eating, psychosis, use of substances; and
- those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations

14.38 be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the service user

14.39 be able to implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy, including the use of cognitive behavioural therapy

14.40 be able to promote awareness of the actual and potential contribution of psychological services

14.41 be able to evaluate and respond to organisational and service delivery changes, including the provision of consultation

Counselling psychologists only

14.42 be able to contrast, compare and critically evaluate a range of models of therapy

14.43 be able to draw on knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities

14.44 be able to critically evaluate theories of mind and personality

14.45 understand therapy through their own life-experience

14.46 be able to adapt practice to take account of the nature of relationships throughout the lifespan

14.47 be able to formulate service users' concerns within the chosen therapeutic models

14.48 be able to critically evaluate psychopharmacology and its effects from research and practice

14.49 be able to critically evaluate theories of psychopathology and change

14.50 be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the service user

14.51 be able to implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy

14.52 be able to promote awareness of the actual and potential contribution of psychological services

14.53 be able to evaluate and respond to organisational and service delivery changes, including the provision of consultation

Educational psychologists only

14.54 be able to develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models

14.55 be able to carry out and analyse large-scale data gathering, including questionnaire surveys

14.56 be able to work with key partners to support the design, implementation, conduct, evaluation and dissemination of research activities and to support evidence-based research

14.57 be able to formulate interventions that focus on applying knowledge, skills and expertise to support local and national initiatives

14.58 be able to develop and apply effective interventions to promote psychological wellbeing, social, emotional and behavioural development and to raise educational standards

14.59 be able to implement interventions and plans through and with other professions and with parents or carers

14.60 be able to adopt a proactive and preventative approach in order to promote the psychological wellbeing of service users

14.61 be able to choose and use a broad range of psychological interventions, appropriate to the service user's needs and setting

14.62 be able to integrate and implement therapeutic approaches based on a range of evidence-based psychological interventions

14.63 be able to promote awareness of the actual and potential contribution of psychological services

Forensic psychologists only

14.64 be able to plan and design training and development programmes

14.65 be able to plan and implement assessment procedures for training programmes

14.66 be able to promote awareness of the actual and potential contribution of psychological services

14.67 be able to assess social context and organisational characteristics

14.68 be able to research and develop psychological methods, concepts, models, theories and instruments in forensic psychology

14.69 be able to evaluate and respond to organisational and service delivery changes, including the provision of consultation

14.70 be able to draw on knowledge of developmental and social changes and constraints across an individual's lifespan to facilitate adaptability and change

14.71 be able to implement interventions and care-plans through and with other professionals who form part of the service user care-team

14.72 be able, on the basis of empirically derived psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting maladaptive or socially damaging behaviour of the service user

14.73 be able to integrate and implement evidence-based psychological therapy at either an individual or group level

Health psychologists only

14.74 be able to plan and implement assessment procedures for training programmes

14.75 be able to develop appropriate psychological assessments based on appraisal of the influence of the biological, social and environmental context

14.76 be able to develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models

14.77 be able to carry out and analyse large-scale data gathering, including questionnaire surveys

14.78 be able to draw on knowledge of developmental, social and biological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities

14.79 be able to contrast, compare and critically evaluate a range of models of behaviour change

14.80 understand techniques and processes as applied when working with different individuals who experience difficulties

14.81 be able to develop and apply effective interventions to promote psychological wellbeing, social, emotional and behavioural development and to raise educational standards

14.82 be able to evaluate and respond to change in health psychology and in consultancy and service-delivery contexts

14.83 be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem, and to the psychological and social circumstances of the service user

14.84 be able to integrate and implement therapeutic approaches based on a range of evidence-based psychological interventions

14.85 be able to choose and use a broad range of psychological interventions, appropriate to the service user's needs and setting

Occupational psychologists only

14.86 be able to assess individuals, groups and organisations in detail

14.87 be able to use the consultancy cycle

14.88 be able to research and develop psychological methods, concepts, models, theories and instruments in occupational psychology

14.89 be able to use psychological theory to guide research solutions for the benefit of organisations and individuals

14.90 understand and be able to act and provide advice on policy development concerning employees' and job seekers' rights

14.91 be able to run, direct, train and monitor others in the effective implementation of an application

Sport and exercise psychologists only

14.92 be able to assess social context and organisational characteristics

14.93 be able to develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models

14.94 be able to formulate service users' concerns within the chosen intervention models

15 understand the need to establish and maintain a safe practice environment

15.1 understand the need to maintain the safety of both service users and those involved in their care or experience

15.2 be aware of applicable health and safety legislation, and any relevant safety policies and procedures in force at the workplace, such as incident reporting, and be able to act in accordance with these

15.3 be able to establish safe environments for practice, which minimise risks to service users, those treating them and others

Sport and exercise psychologists only

15.4 be aware of the possible physical risks associated with certain sport and exercise contexts

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APPENDIX 2

hpc health professions council

Your duties as a registrant

Standards of conduct, performance and ethics

Contents

Foreword

I am pleased to present the Health Professions Council's standards of conduct, performance and ethics.

We first published the standards of conduct, performance and ethics when our Register opened in July 2003. We began to review them in July 2006 to make sure that they continued to be fit for purpose and meet the expectations of the public, registrants and other stakeholders. The review was led by the Conduct and Competence Committee. We also held a formal consultation process on the draft standards. The review process and consultation produced extremely valuable feedback and we are grateful to everyone who gave their time to help us in shaping the standards that follow.

As part of that consultation process, we agreed some broad principles which have influenced the standards laid out in this document.

We decided that the standards should:

- focus, where possible, on providing guidance to registrants, based on our expectations of their behaviour;
- be based on over-arching principles with some more detail on important points (with more detailed guidance available elsewhere, if necessary);
- apply to all registrants (as far as possible), including those involved in research, clinical practice, education and roles in industry; and
- be written in broad terms to be able to take account of changes in best practice, technology, the law and wider society in the future.

We made a number of changes to the previous standards, mainly to set out our aims more clearly or to correct any mistakes. We also revised the introduction to focus less on the role of the standards in fitness to practise procedures and we added more information on how registrants can use and meet the standards.

I am confident that the standards are both fit for purpose and reflect both professional and public expectations of the behaviour of registrants.

These standards apply from 1 July 2008.

Anna van der Gaag

Anna van der Gaag
President

Introduction

Your duties as a registrant

The standards of conduct, performance and ethics you must keep to

1 You must act in the best interests of service users.

2 You must respect the confidentiality of service users.

3 You must keep high standards of personal conduct.

4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

5 You must keep your professional knowledge and skills up to date.

6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

7 You must communicate properly and effectively with service users and other practitioners.

8 You must effectively supervise tasks that you have asked other people to carry out.

9 You must get informed consent to give treatment (except in an emergency).

10 You must keep accurate records.

11 You must deal fairly and safely with the risks of infection.

12 You must limit your work or stop practising if your performance or judgement is affected by your health.

13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.

14 You must make sure that any advertising you do is accurate.

This document sets out the standards of conduct, performance and ethics we expect from the health professionals we register. The standards also apply to people who are applying to become registered.

If you are registered, you must make sure that you are familiar with the standards and that you keep to them. If you are applying to be registered, you will be asked to sign a declaration to confirm that you have read and will keep to the standards once you are registered.

We also publish **standards of proficiency**, which are standards we use to make sure the professions we regulate work safely and effectively. We set these standards at a level we think is necessary to protect members of the public.

What we expect of you

The standards of conduct, performance and ethics play an important role in helping us make decisions about the character of the people who apply to our Register, and also in cases where we decide whether someone is fit to practise.

It is important that you read and understand this document. If someone raises concerns about your practice, we will consider these standards (and our standards of proficiency) when we decide whether we need to take any action. Please see the back of this document for more information about how we use the standards when we consider complaints.

The standards and your practice

The standards are written in broad terms and designed to apply to all registrants as far as possible. However, we recognise that some of the standards may not apply to all the professions that we regulate or to the practice of some registrants. The standards that might not directly apply to all registrants include standard eleven, which says that ‘You must deal fairly and safely with the risks of infection’.

If we receive a complaint about you, the fitness to practise panel will consider the individual circumstances of the case (for example, the profession you work in and your scope of practice).

Meeting the standards

It is important that you meet our standards and are able to practise safely and effectively. We also want to make sure that you maintain high standards of personal conduct and do not do anything which might affect the public's confidence in you or your profession. However, we do not dictate how you should meet our standards.

Each standard can normally be met in more than one way. The way in which you meet our standards might change over time because of improvements in technology or changes in your practice.

As an autonomous and accountable professional, you need to make informed and reasonable decisions about your practice to make sure that you meet the standards that are relevant to your practice. This might include getting advice and support from education providers, employers, professional bodies, colleagues and other people to make sure that you protect the wellbeing of service users at all times.

In particular, we recognise the valuable role professional bodies play in representing and promoting the interests of their members. This often includes providing guidance and advice about good practice, which can help you meet the standards in this document.

Making informed and reasonable decisions

We often receive questions from registrants who are concerned that something they have been asked to do, a policy, or the way in which they work might mean that they cannot meet our standards. They are often worried that this might have an effect on their registration.

If you make informed, reasonable and professional judgements about your practice, with the best interests of your service users as your prime concern, and you can justify your decisions if you are asked to, it is very unlikely that you will not meet our standards.

By ‘informed’, we mean that you have enough information to make a decision. This would include reading these standards and taking account of any other relevant guidance or laws. By ‘reasonable’, we mean that you need to make sensible, practical decisions about your practice, taking account of all relevant information and the best interests of the people who use or are affected by your services. You should also be able to justify your decisions if you are asked to.

Language

Our registrants work in a range of different settings, which include clinical practice, education, research and roles in industry. We have tried to use terms which are as broad as possible and which everyone can understand.

Throughout these standards, we have used the term ‘service user’ to refer to anyone who uses or is affected by a registrant’s services. Who your service users are will depend on how and where you work. For example, if you work in clinical practice, your service users might be your patients. In some circumstances, your service users might be organisations rather than individuals. The term also includes other people who might be affected by your practice, such as carers and relatives.

We have used the word ‘treatment’ in its broadest sense to include a number of actions registrants carry out. These actions could include diagnostic or monitoring procedures, therapy or advice.

Changing these standards in the future

We have produced this new version of our standards after speaking to our stakeholders about how the standards were working, how they were seen and how relevant they were to registrants’ practice.

We will continue to listen to our stakeholders and review our standards. We may make changes to the standards in the future to take account of changes in practice or public and professional expectations.

Contact us

If you are not sure how to interpret the standards, you should write to our Director of Policy and Standards at the following address.

Policy and Standards Department
Health Professions Council
Park House
184 Kennington Park Road
London
SE11 4BU

Email: policy@hpc-uk.org

The standards of conduct, performance and ethics

1 You must act in the best interests of service users.

You are personally responsible for making sure that you promote and protect the best interests of your service users. You must respect and take account of these factors when providing care or a service, and must not abuse the relationship you have with a service user. You must not allow your views about a service user's sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you treat them or the professional advice you give. You must treat service users with respect and dignity. If you are providing care, you must work in partnership with your service users and involve them in their care as appropriate.

You must not do anything, or allow someone else to do anything, that you have good reason to believe will put the health or safety of a service user in danger. This includes both your own actions and those of other people. You should take appropriate action to protect the rights of children and vulnerable adults if you believe they are at risk, including following national and local policies.

You are responsible for your professional conduct, any care or advice you provide, and any failure to act. You are responsible for the appropriateness of your decision to delegate a task. You must be able to justify your decisions if asked to.

You must protect service users if you believe that any situation puts them in danger. This includes the conduct, performance or health of a colleague. The safety of service users must come before any personal or professional loyalties at all times. As soon as you become aware of a situation that puts a service user in danger, you should discuss the matter with a senior colleague or another appropriate person.

2 You must respect the confidentiality of service users.

You must treat information about service users as confidential and use it only for the purposes they have provided it for. You must not knowingly release any personal or confidential information to anyone who is not entitled to it, and you should check that people who ask for information are entitled to it.

You must only use information about a service user:

- to continue to care for that person; or
- for purposes where that person has given you specific permission to use the information.

You must also keep to the conditions of any relevant data-protection laws and always follow best practice for handling confidential information. Best practice is likely to change over time, and you must stay up to date.

3 You must keep high standards of personal conduct.

You must keep high standards of personal conduct, as well as professional conduct. You should be aware that poor conduct outside of your professional life may still affect someone's confidence in you and your profession.

4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

You must tell us (and any other relevant regulators) if you have important information about your conduct or competence, or about other registrants and health professionals you work with. In particular, you must let us know straight away if you are:

- convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution;
- disciplined by any organisation responsible for regulating or licensing a health-care or social-care profession; or
- suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.

You should co-operate with any investigation or formal inquiry into your professional conduct, the conduct of any other health-care provider or the treatment of a service user, where appropriate. If anyone asks for relevant information in connection with your conduct or competence, and they are entitled to it, you should provide the information.

We can take action against you if you are convicted of a criminal offence or have accepted a police caution. We will always consider each case individually to decide whether we need to take any action to protect the public.

However, we will consider rejecting an application for registration, or removing you from the Register if you are already registered, if you are convicted of a criminal offence or accept a police caution that involves one of the following types of behaviour.

- Violence
- Abuse
- Sexual misconduct
- Supplying drugs illegally
- Child pornography
- Offences involving dishonesty
- Offences for which you received a prison sentence

This is not a full list. We will always look at any convictions or cautions we find out about, and we have arrangements in place to be told about convictions and cautions involving registrants.

5 You must keep your professional knowledge and skills up to date.

You must make sure that your knowledge, skills and performance are of a good quality, up to date, and relevant to your scope of practice.

You must be capable of meeting the standards of proficiency that apply to your scope of practice. We recognise that your scope of practice may change over time.

We acknowledge that our registrants work in a range of different settings, including education, research and clinical practice. You need to make sure that whatever your area of practice, you are capable of practising safely and effectively.

Our standards for continuing professional development link your learning and development to your continued registration. You also need to meet these standards.

6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

You must keep within your scope of practice. This means that you should only practise in the areas in which you have appropriate education, training and experience. We recognise that your scope of practice may change over time.

When accepting a service user, you have a duty of care. This includes the duty to refer them for further treatment if it becomes clear that the task is beyond your own scope of practice. If you refer a service user to another practitioner, you must make sure that the referral is appropriate and that the service user understands why you are making the referral.

In most circumstances, a person is entitled to be referred to another practitioner for a second opinion. In these cases, you must accept the request and make the referral as soon as you can.

If you accept a referral from another practitioner, you must make sure that you fully understand the request. You should only provide the treatment if you believe that this is appropriate. If this is not the case, you must discuss the referral with the practitioner who made the referral, and also the service user, before you begin any treatment or provide any advice.

7 You must communicate properly and effectively with service users and other practitioners.

You must take all reasonable steps to make sure that you can communicate properly and effectively with service users. You must communicate appropriately, co-operate, and share your knowledge and expertise with other practitioners, for the benefit of service users.

8 You must effectively supervise tasks you have asked other people to carry out.

People who consult you or receive treatment or services from you are entitled to assume that a person with appropriate knowledge and skills will carry out their treatment or provide services. Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice.

You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely and effectively, you must not force them to carry out the task anyway. If their refusal raises a disciplinary or training issue, you must deal with that separately, but you should not put the safety of the service user in danger.

9 You must get informed consent to give treatment (except in an emergency).

You must explain to the service user the treatment you are planning on carrying out, the risks involved and any other possible treatments. You must make sure that you get their informed consent to any treatment you do carry out. You must make a record of the person's decisions for treatment and pass this on to other members of the health-care or social-care team involved in their care. In emergencies, you may not be able to explain treatment, get consent or pass on information to other members of the health-care or social-care team. However, you should still try to do all of these things as far as you can.

A person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure that they are fully aware of the risks of refusing treatment, particularly if you think that there is a significant or immediate risk to their life.

You must keep to your employers' procedures on consent and be aware of any guidance issued by the appropriate authority in the country you practise in.

10 You must keep accurate records.

Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services. You must complete all records promptly. If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries.

You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user.

You must protect information in records from being lost, damaged, accessed by someone without appropriate authority, or tampered with. If you update a record, you must not delete information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).

11 You must deal fairly and safely with the risks of infection.

You must not refuse to treat someone just because they have an infection. Also, you must keep to the rules of confidentiality when dealing with people who have infections. For some infections, such as sexually transmitted infections, these rules may be more restrictive than the rules of confidentiality for people in other circumstances. We discussed confidentiality in more detail earlier in this document.

You must take appropriate precautions to protect your service users and yourself from infection. In particular, you should protect your service users from infecting one another. You must take precautions against the risk that you will infect someone else.

This is especially important if you suspect or know that you have an infection that could harm other people. If you believe or know that you may have this kind of infection, you must get medical advice and act on it. This may include the need for you to stop practising altogether, or to change your practice in some way in the best interests of protecting your service users.

12 You must limit your work or stop practising if your performance or judgement is affected by your health.

You have a duty to take action if your physical or mental health could be harming your fitness to practise. You should get advice from a consultant in occupational health or another suitably qualified medical practitioner and act on it. This advice should consider whether, and in what ways, you should change your practice, including stopping practising if this is necessary.

13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.

You must justify the trust that other people place in you by acting with honesty and integrity at all times. You must not get involved in any behaviour or activity which is likely to damage the public's confidence in you or your profession.

14 You must make sure that any advertising you do is accurate.

Any advertising you do in relation to your professional activities must be accurate. Advertisements must not be misleading, false, unfair or exaggerated. In particular, you should not claim your personal skills, equipment or facilities are better than anyone else's, unless you can prove this is true.

If you are involved in advertising or promoting any product or service, you must make sure that you use your knowledge, skills and experience in an accurate and responsible way. You must not make or support unjustifiable statements relating to particular products. Any potential financial reward should not play a part in the advice or recommendations of products and services you give.

Fitness to practise

When we say someone is ‘fit to practise’, we mean that they have the skills, knowledge, character and health to practise their profession safely and effectively.

We consider complaints about registrants from members of the public, employers, professionals, the police and other people and take action to protect the public. This can include cautioning a registrant, placing conditions on their registration, suspending them from practice or, in the most serious cases, removing them from the Register.

When we consider a complaint about a registrant, we take account of whether the standards have been met when we decide whether we need to take any action to protect the public. We will also take account of any guidance or codes of practice produced by professional bodies.

You can find more information about the fitness to practise process in our brochures ‘Making a complaint about a health professional’ and ‘What happens if a complaint is made about me?’. These brochures are available to download from our website or you can contact us to ask for a copy.

Glossary

You may not be familiar with some of the terms we use throughout this document, so we have explained them below.

Accountable

As an accountable health professional, you will be responsible for the decisions you make and you may also be asked to justify them.

Autonomous

As an autonomous health professional, you make your own decisions based on your own judgement.

Delegate, delegation

When a health professional asks someone else (such as a colleague, student or support worker) to carry out a task on their behalf.

Fit to practise

When someone has the skills, knowledge, character and health to do their job safely and effectively.

Informed consent

When a service user has all the necessary information in a format they can understand so that they can make an informed decision about whether they want to have a particular treatment.

Referral

When a health professional asks another practitioner to take over the care of a service user because it is beyond their scope of practice or because the service user has asked for a second opinion.

Scope of practice

The area or areas of a health professional's profession where they have the knowledge, skills and experience to practise safely and effectively.

Service user

Anyone who uses or is affected by the services of registrants.

Standards for continuing professional development

Standards which link a health professional's ongoing learning and development with their continued registration.

Standards of proficiency

Standards which make sure each profession practises safely and effectively. Health professionals must meet these standards to become registered.

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Information for registrants

Continuing professional development and your registration

Contents

Introduction

About this document

We have written this document to provide information and guidance to registrants about our requirements for continuing professional development (CPD).

All registrants must meet our standards for continuing professional development. We carry out audits every time a profession renews its registration to make sure that our standards are being met.

How this document is structured

- Section one provides information about the HCPC.
- Section two provides a summary of our requirements for registrants.
- Section three explains more about the CPD standards and why we have them.
- Section four explains how you can meet the CPD standards.
- Section five explains what happens if you are audited.
- Section six provides guidance about completing a CPD profile.
- Section seven gives contact details for more information.

Language

Throughout this document:

- ‘health and care professional’ or ‘registrant’ refers to a professional on our Register;
- ‘service user’ refers to anyone who uses or is affected by a registrant’s practice;
- ‘the standards’ refers to the CPD standards;
- ‘we’ or ‘us’ refers to the Health and Care Professions Council (HCPC); and
- ‘you’ or ‘your’ refers to a registrant.

About us

We are a regulator and were set up to protect the public. To do this, we keep a register of professionals who meet our standards for their professional skills and behaviour. Individuals on our register are called ‘registrants’.

We currently regulate 16 professions:

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Social workers in England
- Speech and language therapist

Section 2 – Summary

This section summarises our requirements for registrants.

CPD and registration

- CPD is the way in which you continue to learn and develop throughout your career so you keep your skills and knowledge up to date and are able to practise safely and effectively.
- CPD is not only formal courses but any activity from which you learn and develop.
- CPD is a requirement of your registration, so you need to meet our CPD standards to stay registered.

Meeting the CPD standards

You need to do the following.

- Carry out regular CPD and keep a record of what you do in the way that is most convenient for you.
- Carry out different kinds of learning activities.
- Think about how your CPD might improve your practice and benefit your service users.
- Take part in an audit if we ask you to. We audit a random sample of each profession at every renewal.

If you are audited

You will only form part of the sample picked for audit if you have been registered for two years or more. If you are picked for audit, you need to do the following.

- Renew your registration by completing the professional declarations and paying the registration fee (as you normally would).
- Complete a CPD profile explaining how you have met the CPD standards and send it to us by the deadline.
- Provide supporting evidence with your CPD profile to show us that you have carried out CPD which meets the standards. Don’t forget to include a dated list of all the activities you have carried out since you last renewed your registration. Explain any gaps in your CPD of three or more consecutive months.

Section 3 – About the CPD standards

This section provides more information about the CPD standards and why we have them.

What is CPD?

CPD is the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to practise safely and effectively.

CPD is not just formal courses. A CPD activity is any activity from which you learn and develop. This might include the following.

- **Work-based learning.** For example, reflecting on experiences at work, considering feedback from service users or being a member of a committee.
- **Professional activity.** For example, being involved in a professional body or giving a presentation at a conference.
- **Formal education.** For example, going on formal courses or carrying out research.
- **Self-directed learning.** For example, reading articles or books.

We have provided a longer list of possible CPD activities in appendix 1. It is not a full list and there may be other activities not listed that still help you to learn and develop and which can be part of your CPD.

CPD standards

CPD is linked to registration, so you need to meet our CPD standards to stay registered. There are five CPD standards.

A registrant must:

1. maintain a continuous, up-to-date and accurate record of their CPD activities;
2. demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
4. seek to ensure that their CPD benefits the service user; and
5. upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD.

In section four we explain what you need to do to meet each standard.

A flexible approach based on outcomes

We have developed our approach to CPD to be flexible enough to take account of the range of different health and care professionals registered with us, different working roles and learning needs and variation in registrants' access to certain types of CPD.

We do not set a number of hours or points that you have to complete and we do not 'approve' or 'endorse' any CPD activities. Instead we want you to identify your development needs and choose appropriate activities to help you meet them. We are much more interested in the outcomes of your learning and how this has benefited your practice and the service users you work with.

This means that you can plan your CPD based on the kinds of activities that are most relevant to you and your practice.

The role of employers

We regulate individual health and care professionals and do not have any role in regulating employers. So, the CPD standards are a personal responsibility that all registrants have to meet to stay registered with us.

However, responsible employers will want to encourage the learning and development of their employees to make sure employees stay on the Register. We communicate regularly with employers to make sure that they are aware of the standards and what they mean for their employees.

CPD and fitness to practise

CPD is linked to registration and we can remove you from the Register if you do not meet our CPD standards.

We have a separate process (our fitness to practise process) for dealing with concerns about the conduct and competence of our registrants.

Although there is no direct link to the fitness to practise process, our standards for CPD are all about making sure you continue to learn and develop so that you can stay fit to practise and improve your practice for the benefit of your service users.

Section 4 – Meeting the standards

This section provides more information about how you can meet the standards. There is more information about the audits in section five.

The standards in more detail

We have taken each standard below and explained what it means.

Standard 1: A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities

What the standard means

- You need to carry out regular CPD activities – you can find examples of these in appendix 1.
- You need to keep a record of what you do in whatever way is most convenient for you.
- You need to add to your record on an ongoing basis. If you are audited, we will be interested in what you have done over the previous two years (the length of each registration cycle).
- Your record needs to be a true reflection of the activities that you have carried out.

Keeping your record

We do not ask for a set format for recording your CPD. You might choose to keep a binder or folder including documents such as certificates and notes that you have kept relating to your CPD, or you might keep this record electronically. You might follow a format provided by your professional body or by your employer. Please make sure that you can access your record – for example, in case you leave your employer.

This is your personal record. We will not ask to see a complete copy, but if you were audited, we would ask you to give us details of the activities you have completed over the previous two years and send us some supporting evidence. So keeping a good record will mean that you can do this easily. You can find examples of the types of evidence you might want to keep in appendix 2.

Standard 2: A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice

What the standard means

- Your CPD must include a mixture of different types of learning.
- Your CPD must relate to your registration and practice as a health and care professional.

Mixture of activities

Your CPD must include a mixture of different types of learning. This means that you need to carry out at least two different types of learning activity. In practice, most registrants will carry out many different types of learning while registered with us. We have provided a longer list of possible CPD activities in appendix 1.

If you were audited and had only carried out one type of learning – for example, if you had only read professional journals but had not carried out any other kind of learning – you would not meet this standard.

Your practice

Your CPD must be relevant to your current or future practice. This means that your CPD should be related in some way to your registration as a health and care professional.

Your CPD will be relevant to your practice so will be individual to you. For example, if you are managing a team, some of your CPD might be based around your skills as a manager. If you work in private practice, some of your CPD might be about the skills you need to run a successful practice.

Your CPD can also support your career development. So some or all of your CPD might be about preparing you for a future role.

If you have an annotation on the Register (for example, in prescribing), we would particularly encourage you to consider whether you need to complete some CPD activities to keep up to date in this area of practice.

You are able to make your own decisions about the CPD that is most beneficial to you, your practice and your future career ambitions.

Interactive activities

There is some developing evidence that suggests that the most effective learning activities are often those that are 'interactive' and which encourage 'self-reflection'. For example, 'peer discussion' is a term used to describe opportunities to discuss practice issues with groups of professional colleagues. Although this is not a specific requirement, we would encourage you to look for opportunities to learn and reflect on your practice with others.

Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery

What the Standard means

- You should aim for your CPD to improve the way you work.
- If you were audited, we would ask you to tell us about some of the activities you have carried out, what you learnt and how this has improved your practice.

Quality of practice and service delivery

Your CPD should lead to you making changes to how you work which improves the service that you provide.

You do not necessarily have to make drastic changes to how you work. Some CPD activities might mean that you continue to work as you did before, but that you are more confident that you are working effectively. Others might help you gain new or improved skills or help you to make changes to working practices.

'Seek to ensure'

We use the term 'seek to ensure' in standard 3 because there may be some instances where the CPD activity you carried out to improve your practice is not as effective as you thought it would be. You cannot always anticipate the actual benefits of CPD activity. The important thing is to consider why the activity was not as helpful as you thought it would be, and how you might do things differently in future. As long as you can explain this if asked, you will still meet this standard.

Standard 4: A registrant must seek to ensure that their CPD benefits the service user

What the standard means

- You should aim for your CPD to benefit your service users.
- If you were audited, we would ask you to tell us about some of the activities you have carried out, what you learnt and how this has benefited your service users.

Benefits the service user

For the purposes of this standard, we define a 'service user' as anyone who uses your services or is affected by your work.

Who your service users are will depend on how and where you work. For example:

- if you are in 'front line' or laboratory-based practice, your service users might include patients, clients, carers, other professionals and others you provide services to;

- if you work in education, your service users might include your students; and
- if you are a manager, your service users might include the team that you manage.

The above is not a full list, so you will need to think about who your service users are.

Your CPD should lead to benefits for your service users. These benefits do not need to be radical and in many cases may simply be a result of improvements you have made to your practice. For example, a CPD activity has improved your practice because you have gained new skills, and as a result you are able to provide a better service to your service users. This standard is asking you to think about how your CPD has benefited those who you work with and who are affected by your practice.

‘Seek to ensure’

We use the phrase ‘seek to ensure’ in standard 4 because you might carry out a CPD activity to provide benefits to service users, but find that it is not as helpful as you had expected. As long as you think about why the activity was not useful and what you might do in future instead, and can explain this if asked, you will still meet this standard.

Third-party feedback

Asking for, receiving and reflecting on feedback from service users and peers can help improve practice and help to identify future learning needs.

Although this is not a specific requirement, we would encourage you to ask for and reflect on feedback from service users and others if you are able to. This feedback can also be a useful piece of evidence to support the fact that you have met standard four (see section six).

Standard 5: A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD

What the standard means

- You only need to meet this standard if you are one of the registrants picked as part of a random sample for audit.
- You need to take part in the audit by sending us a CPD profile containing information and evidence about how you have met the standards.
- The CPD profile must be your own work.

We explain more about taking part in an audit and completing a CPD profile in sections five and six.

Your own work

If you are audited, the CPD profile must be your own work. A profile which was written by someone else, or included text from profiles produced by others, would not meet this standard.

If we suspect that a CPD profile is not your own work but, for example, includes plagiarised material, we would stop the assessment process and investigate this under our fitness to practise process.

This does not mean that you cannot ask a colleague for help and we would encourage you to discuss your CPD audit with your colleagues if you feel you need help.

CPD schemes

As our standards are based on outcomes, there are lots of different ways in which you might meet them.

You could meet our requirements by choosing to take part in a scheme run by your professional body, your employer or any other organisation. Most CPD schemes will give you the opportunity to meet our standards and offer a useful way of structuring and recording your CPD activities.

As we do not approve any CPD schemes, you still need to make sure that you are content that taking part in a scheme will allow you to meet our standards. If you were audited, you would draw on the different activities that you had completed as part of the scheme to demonstrate how you have met our standards.

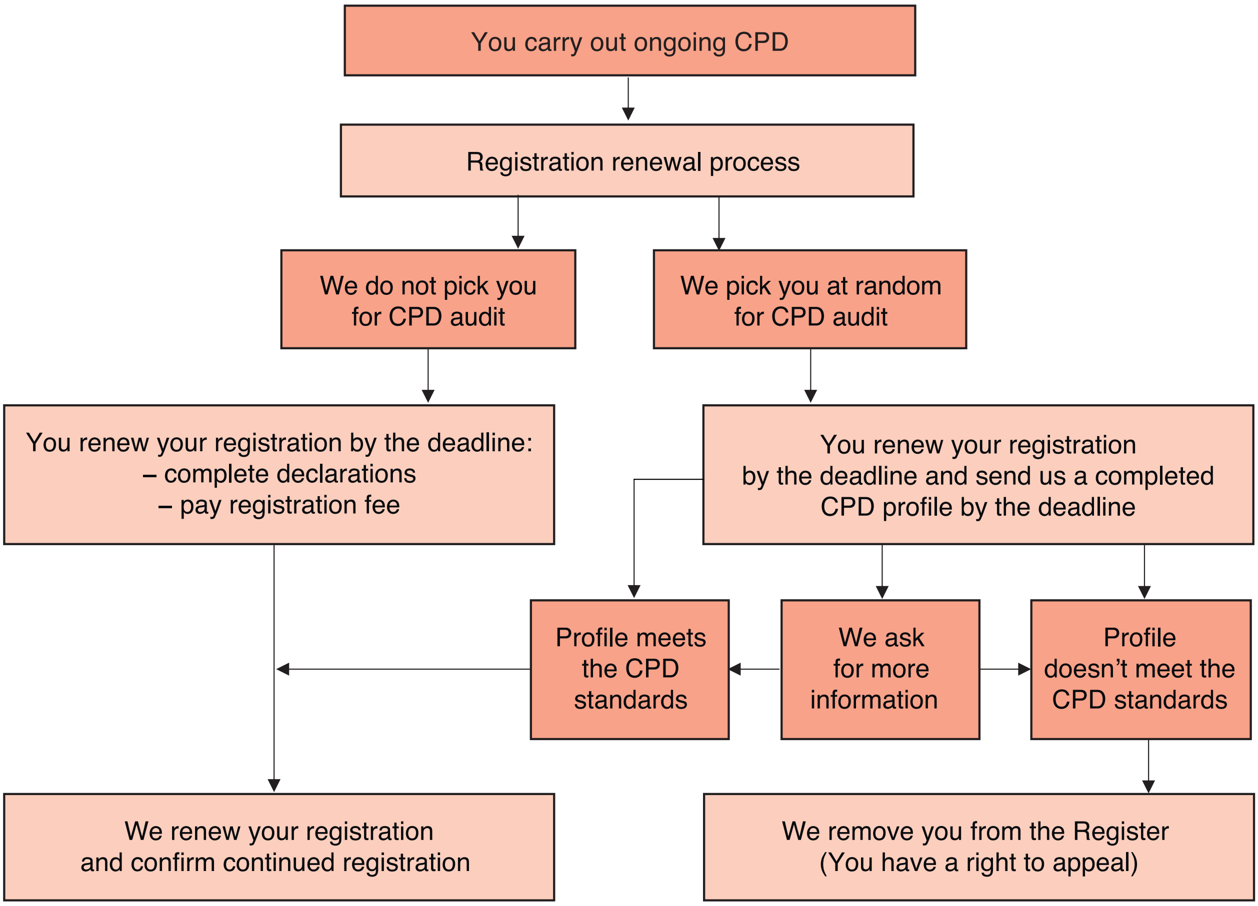
Our CPD standards are also complementary to CPD frameworks which are sometimes published by service providers or by professional bodies and which link learning and development to career development and progression.

Section 5 – The audit process

This section explains more about the audit process. If we pick you as part of the random sample for audit, we will send you information about exactly what you need to do.

The audit process in summary

The following is a simple summary of the audit process.



The audit process in more detail

Selection for audit

Each profession renews its registration every two years. When you renew your registration, we ask you to complete a declaration to confirm that you have met our standards, including the standards for CPD.

We audit a random sample of 2.5 per cent of registrants in each profession at every renewal and ask these individuals to send us information and evidence that they have met the CPD standards. We review this percentage regularly and we may change it in the future.

We will only audit registrants who have been registered for two years or more. This means that if you are a recent graduate, we will not choose you for audit when you renew your registration for the first time. Similarly, if you have had a break in registration and have just come back onto the Register, we will not choose you the first time you renew your registration.

The audit selection is computer-generated at random. As CPD is an ongoing requirement while you are registered, it is possible that you could be picked for audit on multiple occasions.

Completing the audit

If you are picked as part of the random sample for audit, we will send you information about completing your CPD profile. You will need to complete and send us your profile by your renewal deadline date. If circumstances mean that you cannot take part in an audit, you can make a request to defer your audit (see page 14).

You will have approximately three months in which to complete and send us your profile. We will also remind you approximately one month before the deadline. You can find examples of completed CPD profiles on our website.

If you do not send us a CPD profile or any information we ask for as part of the audit process, we may remove you from the Register. You would be able to appeal this decision (please see page 13).

You also need to renew your registration as you normally would – by completing the renewal declarations and paying the registration fee. If you do not renew your registration, we will remove you from the Register.

We may not be able to assess your profile by the end of your registration cycle. If that happens and you have completed your renewal, we will renew your registration in the normal way so that you can continue to practise. We will then continue to assess your profile.

When we have received your profile

When we receive your completed profile, we will check that it is complete (for example, that you have included some evidence). If something is missing, we will ask you for the missing information.

We will ask CPD assessors to assess your CPD profile against the standards. CPD assessors are registrants we appoint and train to assess profiles, and at least one of them will be from the same profession as you. In appendix 3, we have broken down each standard into ‘assessment criteria’ so you can see what meeting and not meeting a standard might look like.

While we are assessing your profile (and if you were to appeal against any decision) you will continue to stay registered and can continue to practise.

Assessment outcomes

Once we have assessed your profile, there are three possible outcomes.

– **Your profile meets the standards.** We will contact you and let you know.

- **We ask you for more information.** We will contact you and let you know what information we need to decide whether you meet the CPD standards.
- **Your profile does not meet the standards.**

If your profile does not meet the standards, the CPD assessors will then decide whether or not to offer you extra time (up to an extra three months) to meet the standards. We will normally ask you for more information before we make this decision.

The CPD assessors will decide whether to offer you extra time by considering whether:

- you have made a reasonable attempt to provide a complete CPD profile;
- you have met some of the standards; and
- with extra time it would be possible for you to meet the standards.

You are very likely to be offered extra time if it is clear to the assessors that you are committed to CPD but for whatever reason have struggled to meet some of the CPD standards fully.

If we give you extra time to meet the standards, we will contact you to tell you what we need you to do and by when. This might include, for example, carrying out further CPD or completing a new profile. You will need to send us the information we ask for which we will then assess.

If you do not meet the standards, we will remove you from the Register. Whatever decision we reach, we will let you know our decision and the reasons for it.

Making an appeal

If we decide that your CPD profile does not meet our standards, or you have not taken part in or completed the audit process, and we decide to remove you from the Register, you can appeal against this decision. You will be able to tell us why you think this decision is wrong.

We will let you know exactly what you need to do and by when. If you make an appeal, you will stay on the Register until a decision has been made. Your appeal will be considered by an appeal panel. You can choose to go to an appeal hearing or ask for your appeal to be considered on the documents that you send to the panel.

The appeal panel can decide to:

- agree with you and allow you to stay registered;
- dismiss the appeal, so our original decision to take you off the Register stands; or
- ask us to assess your CPD profile again.

If you do not agree with the panel's decision, you can appeal to the County Court in England, Wales or Northern Ireland or to a local Sheriff Court in Scotland.

Coming back onto the Register

If we decide that your CPD profile does not meet our standards, or you have not taken part in or completed the audit process, and we remove you from the Register, you will be able to apply to us to be registered again in the future.

To come back onto the Register, you will need to apply for 'readmission'. We will ask you for more information about why you previously came off of the Register and about the CPD you plan to carry out if you are registered again. We will then consider this information before making a final decision about your application. If we re-register you, we will include you in the next CPD audit for your profession.

You can find more information about applying for readmission on our website.

Deferral

If we pick you as part of the random sample for audit, but you cannot take part because of your circumstances, you can ask us to defer your audit. This might be because of a serious illness, a bereavement or maternity leave.

We will ask you to send us evidence of why you cannot take part. We will want to make sure that deferring your audit will be fair to you and to the other registrants who have been audited. If your audit is deferred, you will be automatically picked for audit when your profession next renews its registration.

It is your choice about whether to apply for deferral. For example, you may feel that you are able to take part in an audit even if you have been on maternity leave or sick leave for a significant part of the two-year registration cycle. If this is the case, you could choose to take part in the audit and make your circumstances clear in your profile

Section 6 – Putting your CPD profile together

This section provides a brief summary of what we will need from you if we pick you as part of the random sample for audit.

If we do pick you for audit, we will give you more information about what we need you to do, how and by when. This information includes information about the reasonable adjustments we can put in place if you are disabled.

You can find out more in ‘How to complete your Continuing Professional Development profile’ available on our website. You can also find sample CPD profiles for each profession which show you different ways of completing your profile and meeting the standards.

The profile in summary

The profile has four parts.

- **Summary of your practice history (up to 500 words).** In this section, we ask you to describe your current role and the type of work you do. We ask for this information so that we can assess whether your CPD is relevant to your current or future practice (standard two).
- **A statement of how you have met the standards (up to 1,500 words).** In this section, we ask you to draw on the CPD activities you have carried out to show us how you meet the standards.
- **A dated list of the CPD activities you have carried out since you last renewed your registration.**
- **Supporting evidence.** We ask you to give us evidence which shows that the CPD activities you have written about in the profile have taken place.

Writing your statement

In your statement, you will be concentrating most on telling us how you meet standards three and four – how your CPD activities improve the quality of your work and benefit service users.

One way to complete your statement is to choose four to six CPD activities you have carried out and for each one describe:

- what the activity was;
- what you learnt; and
- how you think the activity improved the quality of your work and benefited your service users.

You can choose to tell us about the activities which you think benefited you the most and for which you have some supporting evidence. Writing your statement in this way can be a clear and simple way of showing us how you have met the standards.

However, there is more than one way of completing your statement so this is only a suggestion. Other ways might include using your professional development plan or similar (if you have one) or structuring your statement around each of the CPD standards.

Supporting evidence

You need to send us the following evidence.

- **A dated list of all the CPD activities you have carried out in the last two years** (since you last renewed your registration). This shows us that you have carried out CPD and kept a record (standard one).

Your dated list might be something you produce as a result of the audit, looking at your personal CPD record, or might be something you can produce automatically if you are using an electronic record-keeping system.

Your CPD record must be ‘continuous’ (standard one) but we recognise that CPD activities may not be evenly spaced out during your registration cycle. If you have a gap in your CPD activities of three or more consecutive months, please explain why in your statement. Some activities may take place over a period of time rather than on a specific date. If this is the case, you should state the start and end date in your list of activities.

– **Evidence which shows that the CPD you have written about in the profile has taken place.** You might also provide evidence (if available) of the benefits of your CPD to your practice and service users.

We will look for evidence that the activities you have written about in your statement have taken place. So for example, if you have told us about five activities in your statement, we would expect to see five pieces of supporting evidence.

Appendix 2 at the back of this document provides a list of the different types of evidence you might send us. This could include evidence such as course certificates, as well as evidence you have produced yourself, for example, notes from reading professional journals.

You can also send us evidence of the benefits of your CPD. For example, you may have evidence of a meeting with your manager where you discussed using new skills you had learnt, or you may have evidence of how you personally planned to make changes to systems and practices. But we recognise that for some activities, evidence like this might not be possible. So you should make sure that you explain clearly in your statement what you learnt from an activity and what you think the benefits were and why.

Section 7 – More information

Our website: www.hcpc-uk.org/registrants/cpd contains more information, including:

- guidance on putting a CPD profile together;
- sample CPD profiles;
- the HCPC biennial CPD audit reports; and
- CPD frequently asked questions.

If you have any questions about this document, please contact us. You can contact us at:

Registration Department
Health and Care Professions Council
Park House
184 Kennington Park Road
London
SE11 4BU

Phone: +44 (0)300 500 4472

Email: registration@hcpc-uk.org

Glossary

Appeal	If you do not meet the CPD standards, or you have not taken part in or completed the audit process, and we tell you that we will remove you from the Register, you can ask us to reconsider the decision by making an appeal.
Audit	A CPD audit is the process where we ask a sample of registrants who are renewing their registration to send in a profile showing how their CPD meets our standards.
Continuing professional development (CPD)	CPD is the way in which you continue to learn and develop throughout your career so you keep your skills and knowledge up to date and are able to practise safely and effectively.
CPD assessor	A registrant we have appointed to assess CPD profiles against the CPD standards.
Deferral	If you cannot complete your profile, deferral is the process where you are allowed to put off your CPD audit until your profession next renews its registration.
Fitness to practise	When we say that a registrant is 'fit to practise', we mean that they have the skills, knowledge and character to practise their profession safely and effectively. Fitness to practise is also the name of the process we follow when we consider concerns about the practice or behaviour of a registrant.
Professional body	Each of the professions we regulate has at least one professional body. Professional bodies may support their members, promote the profession and develop best practice.
Profile	If you are audited, this is the information you send to us to show how you meet the standards for CPD.
Readmission	The process by which someone who was registered in the past can apply to be registered again.
Registrant	A health and care professional who is registered by us.
Renewal	The process by which professionals on our Register make a professional declaration and pay their registration fees, so that they can continue to be registered. Each profession renews its registration every two years.
Service user	For the purposes of the standards for CPD, a service user is someone who uses or is affected by a registrant's practice.

Appendix 1: Examples of CPD activities

This list should give you an idea of the kinds of activities that might make up your CPD. (This list has been adapted from work done by the Allied Health Professions' project 'Demonstrating competence through CPD' (2003).)

Work-based learning

- Learning by doing
- Case studies
- Reflective practice
- Audit of service users
- Coaching from others
- Discussions with colleagues
- Peer review
- Gaining and learning from experience
- Involvement in the wider, profession-related work of your employer (for example, being a representative on a committee)
- Work shadowing
- Secondments
- Job rotation
- Journal club
- In-service training
- Supervising staff or students
- Expanding your role
- Significant analysis of events
- Filling in self-assessment questionnaires
- Project work

Professional activities

- Involvement in a professional body, specialist-interest group or other groups
- Lecturing or teaching
- Mentoring
- Being an examiner
- Being a tutor
- Organising journal clubs or other specialist groups
- Maintaining or developing specialist skills (for example, musical skills)
- Being an expert witness
- Giving presentations at conferences
- Organising accredited courses
- Supervising research or students
- Being a national assessor

Formal and educational

- Courses
- Further education
- Research
- Attending conferences
- Writing articles or papers
- Going to seminars
- Distance or online learning
- Going on courses accredited by a professional body
- Planning or running a course

Self-directed learning

- Reading journals or articles
- Reviewing books or articles
- Updating your knowledge through the internet or TV
- Keeping a file of your progress

Other

- Relevant public service or voluntary work

Appendix 2: Examples of evidence

This list should give you an idea of the kinds of evidence of your CPD you could provide. (This list has been adapted from work done by the Allied Health Professions' project 'Demonstrating competence through CPD' (2003).)

Materials you may have produced

- Information leaflets
- Case studies
- Critical reviews
- Policies or position statements
- Documents about national or local processes
- Reports (for example, on project work or audits or reviews)
- Business plans
- Procedures
- Guidance materials
- Guidelines for dealing with service users
- Course assignments
- Action plans
- Course programme documents
- Presentations you have given
- Articles for journals
- Questionnaires
- Research papers, proposals, funding applications
- Induction materials for new members of staff
- Learning contracts
- Contributions to the work of a professional body
- Contributions to the work of a special-interest group

Materials showing you have reflected on and evaluated your learning and work

- Adapted documents arising from appraisals, supervision reviews and so on
- Documents about following local or national schemes relating to CPD
- Evaluations of courses or conferences you have been to
- Personal development plans
- Approved claims for credit for previous learning or experience

Materials you have got from others

- Testimonials
- Letters from service users, carers, students or colleagues
- Course certificates

Appendix 3: Assessment criteria

Assessment criteria

Standard	Standard not met	Standard partly met	Standard met
1. A registrant must maintain a continuous, up-to-date and accurate record of their CPD activities.	You have not provided evidence that you have kept a record of your CPD.	There is some evidence that you have kept a record – for example, you have described keeping a record.	There is evidence that you have kept a record of your CPD activities. You have included a dated list of all the CPD activities you have carried out. If there is a gap of three or more months, you have explained why.
2. A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.	You have not carried out any CPD activities. Or Your CPD consists of only one type of learning activity. Or Your CPD is not relevant to your current or future practice.	There is some evidence that your CPD is relevant to current or future work, but this is not made clear.	Your CPD includes at least two types of learning activity. And Your CPD activities are relevant to your current or future practice.

Assessment criteria

Standard	Standard not met	Standard partly met	Standard met
3. A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.	You have not provided any information which shows that you have thought about how your CPD activities might have improved the quality of your work.	There is some suggestion that your CPD has improved your work but this is not clear.	Your personal statement explains how your CPD activities have improved the quality of your work. Or You have explained how you believed that your CPD would improve the quality of your work but this has not been the case. You have explained why this was and what you will do in the future.
4. A registrant must seek to ensure that their CPD benefits the service user.	You have not provided any information which explains any benefit to service users.	There is limited information or explanation about how your CPD activities have benefited service users.	Your personal statement explains how your CPD activities have benefited your service users. Or You have explained how you believed that your CPD would benefit your service users but this has not been the case. You have explained why this was and what you will do in the future.

Assessment criteria

Standard	Standard not met	Standard partly met	Standard met
5. A registrant must, upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the Standards for CPD.	You did not complete a profile and send it to us by the deadline.	You have provided a profile but it is incomplete (for example, the evidence is missing).	You have sent in a completed profile by the deadline.

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The British Psychological Society (BPS) and Clinical Psychology Training

The British Psychological Society represents the interests of psychologists in the UK. Although its constitution means that it cannot act as a professional body, it does represent the interests of psychologists in professional practice, and that includes clinical psychologists. The Division of Clinical Psychology (DCP) is one of the largest components of the BPS with a membership of around 10,000.

The UCL programme considers that membership of the BPS and support for our professional body is important, and this document is intended:

- to help explain how the BPS and the HCPC work together in relation to setting standards for training and accreditation
- to identify the wider role of the BPS
- to identify the role of the DCP
- to help trainees consider joining the BPS and the pre-qualification group of the DCP

BPS and HCPC roles in setting standards for training and accreditation

Historically the BPS undertook regulation of the profession, setting the criteria for accreditation and regulation of courses across the UK (through the Committee on Training in Clinical Psychology (CTCP)), awarding chartered status to individuals who had completed accredited courses and investigating and ruling on breaches of professional practice.

In 2009 clinical psychologists came under the regulatory authority of the Health and Care Professions Council (HCPC). This involved the creation of a statutory register of practitioner psychologists (with legal protection of the title ‘Clinical Psychologist’), the accreditation of courses offering a Doctorate in Clinical Psychology, and the introduction of a disciplinary procedure. This meant that several functions previously carried out by the BPS transferred to HCPC, raising some questions, and some confusion, about the role of the BPS.

The BPS and the HCPC have different but co-ordinated approaches to the accreditation of programmes.

The HCPC has a statutory role – if it withheld accreditation then graduates from a programme would not be able to register with the HCPC (and so would be unable to practice). The HCPC uses two sets of criteria to come to its judgments: “Standards of Education and Training (SETs)” and “Standards of Proficiency (SOPs)” – both available on the course website. The SETs are common to all educational programmes regulated by the HCPC, but the SOPs focus on areas specific to the profession. It is worth noting that the BPS worked closely with the HCPC to help them identify the SOPs.

Because of its role in accreditation pre-2009 the BPS, – through the CTCP – has a very well-developed set of criteria for evaluating the quality of courses. These have been used to inform the HCPC’s SOPs, but it is worth noting that they are much more comprehensive, and there is general acknowledgment that they represent a more nuanced and professionally-informed set of criteria.

Although (from a statutory perspective) courses do not need accreditation from the BPS, all programmes in the UK have chosen to be jointly accredited by the BPS as well as the HCPC. This is for good reason – it means that graduates are eligible for chartered status as a clinical psychologist with the BPS. It also reflects a commitment to the highest standards, because the BPS criteria are much more detailed and aspirational than those of the HCPC. The current situation is that all courses have been visited and accredited by HCPC, and the BPS continues to undertake accreditation visits to all programmes every 6 years.

The BPS accreditation criteria are regularly reviewed and revised and are available via the BPS website. They have proved very useful in helping the programme think about the training it delivers, and the way in which this is structured. But it is also the case that CTCP is open to influence from practitioners and trainers, and this two-way dialogue means that the quality assurance process is seen as collegial rather than top-down, with the result that there is considerable respect for the BPS quality assurance process.

The wider roles of the BPS

The BPS has a very wide range of functions, some of which are not immediately evident or are treated as a ‘natural’ part of the professional landscape, despite the fact that all the functions involve a considerable expenditure of effort and resource. The consequence is that its role and activities are not always recognised, and a few examples are worth identifying:

Maintaining influence and promoting the profession: Because the BPS has a high profile, it is usually consulted in relation to matters of policy and asked to contribute its views, both scholarly and strategic. Many professional bodies seek to liaise with the BPS – for example, there is a long history of collaboration with the medical colleges in the development of policy and advice, and the National Collaborating Centre (which develops mental health guidelines for NICE) is a joint partnership between the BPS and the Royal College of Psychiatrists.

Setting academic and professional standards: The BPS identify the standards for undergraduate programmes in psychology, and establish the content of degrees that confer Chartered Basis for Registration.

Scholarship: The Society produces a number of academic journals – the most immediately relevant is the British Journal of Clinical Psychology, but there is a suite of society journals, all pertinent to clinical practice.

Other publications: “The Psychologist” is published monthly and is the ‘house journal’ for the society. It includes discussion of current issues and debates as well as lively updates on a wide range of research topics.

Conferences: The BPS organises annual conferences that bring together the various branches of psychology, as well as providing the infrastructure that supports the many conferences hosted by faculties and branches of the DCP.

Ethics: The BPS ethics committee meets regularly to consider ethical issues that impact on psychologists, and is responsible for producing the Code of Ethics and Conduct (available on the BPS website).

The Division of Clinical Psychology (DCP)

The DCP was founded in. It has a number of roles and functions, but primarily it aims to promote clinical psychology as a profession, and to help develop the knowledge and skills that underpin it. The DCP works closely with a number of organisations including the NHS, the government in all four nations, other professional bodies, groups in the voluntary sector and service users and carers.

Reflecting the specialisms that constitute clinical psychology there are 13 ‘faculties’, each of which organises meetings and conferences and, where appropriate, offers advice both within the profession (for example, on training, or on the ways in which services should be delivered) or to external bodies. The faculties are:

- Addiction
- Children, Young People and their Families
- Clinical Health Psychology
- Eating Disorders
- Forensic Clinical Psychology
- Holistic Psychology
- Leadership and Management
- Intellectual Disabilities
- Oncology and Palliative Care
- Perinatal Psychology
- Psychosis and Complex Mental Health
- Psychology of Older People
- HIV and Sexual Health

Across the country there are local DCP ‘branches’; these bring together clinical psychologists both to identify local issues and the ways in which they might be managed, as well as organising CPD events. The branch local to UCL is the London and Home Counties one.

The DCP has a monthly publication (Clinical Psychology Forum), and organises conferences, both through its national committee and local branches.

Joining the BPS and the DCP

Trainees will make their own decisions about whether to join the BPS. The programme would encourage this, for reasons that are hopefully evident from the foregoing text. There are of course differing views about the effectiveness of the BPS, made more acute by a perception that it is not always as responsive as it should be to our professional interests. These are legitimate concerns, but the BPS will only thrive on the basis of the input its members make to it, and this is a particularly important observation in relation to the DCP.

Trainees can join the DCP as members of the Pre-Qualification Group, whose purpose it is to ensure that members have a voice, and which gathers and distributes information and knowledge on current developments that impact on their members.

Membership brings a discount on registration for the DCP Annual Conference and CPD events, and automatically confers membership of the London branch of the DCP and access to the members’ area of the members' area of the DCP and BPS websites.

More information

BPS homepage	www.bps.org.uk/
DCP homepage	www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology

The British
Psychological Society
Promoting excellence in psychology

Standards for the accreditation of Doctoral programmes in clinical psychology

January 2019

www.bps.org.uk/partnership

The British
Psychological Society
Partnership & Accreditation

Contact us

If you have any questions about Accreditation through Partnership, or the process that applies to you please feel free to contact the Partnership and Accreditation Team:
E-mail: pact@bps.org.uk
Tel: +44 (0)116 252 9563

Our address is:
Partnership and Accreditation Team
The British Psychological Society
St Andrews House
48 Princess Road East
Leicester
LE1 7DR

If you have problems reading this document because of a visual impairment and would like it in a different format, please contact us with your specific requirements.
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Contents

Introduction

The British Psychological Society ('the Society') is the learned and professional body, incorporated by Royal Charter, for psychology in the United Kingdom. The key objective of the Society is 'to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge'. The purpose of the Society's accreditation process is to further that objective.

What is accreditation?

Accreditation through Partnership is the process by which the British Psychological Society works with education providers to ensure quality standards in education and training are met by all programmes on an ongoing basis. Our approach to accreditation is based on partnership rather than policing, and we emphasise working collaboratively with programme providers through open, constructive dialogue that allows for exploration, development and quality enhancement.

Benefits of accreditation

Delivering a programme that meets the standards required for accreditation is a significant commitment, and there are many reasons why Society accreditation is worth your investment of time and money:

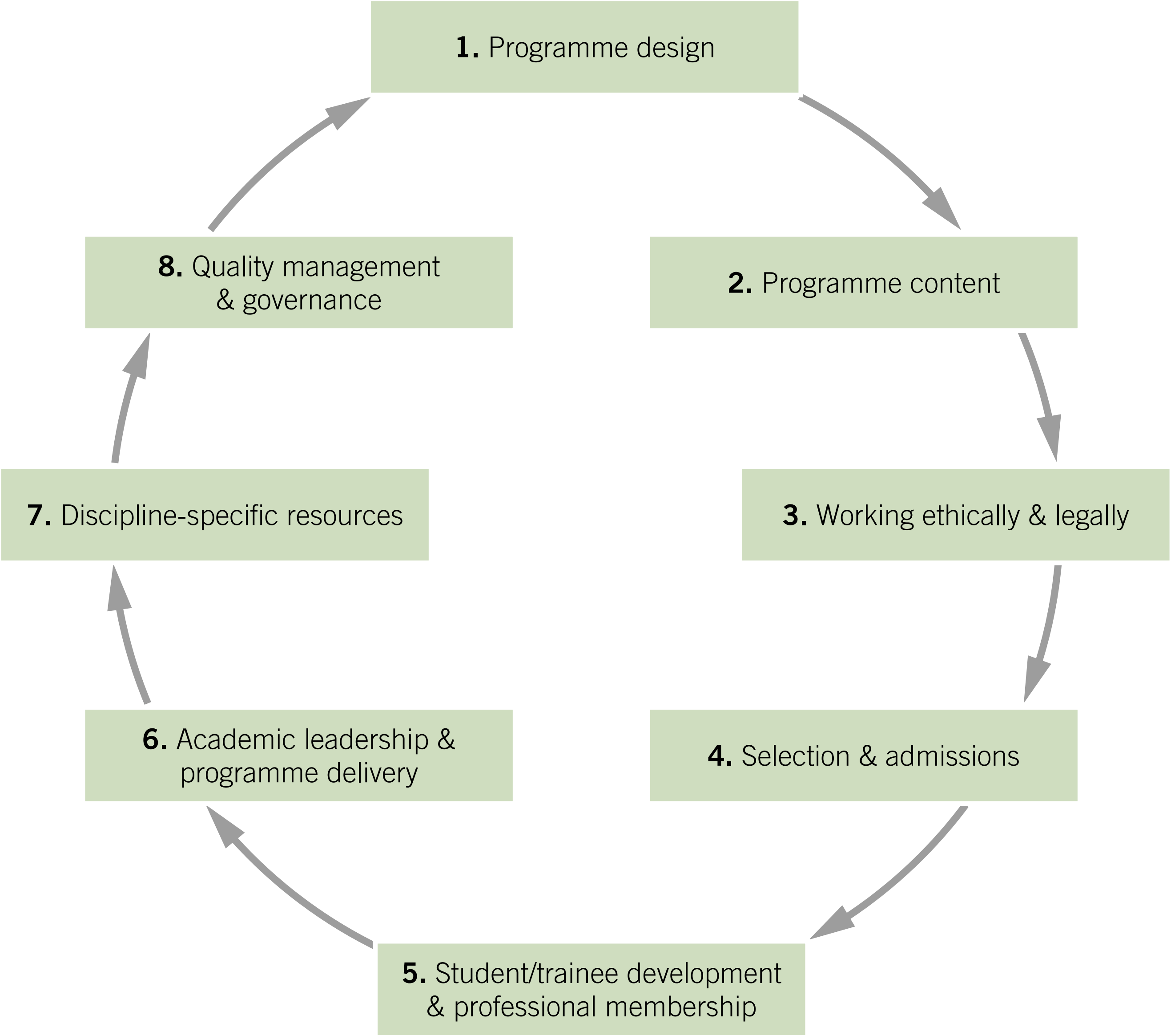
- It is a highly regarded marker of quality that prospective students and employers value.
- It enhances the marketability of your programmes.
- It gives your graduates a route to Society membership, an integral part of students' development as psychologists, or as part of the wider psychological workforce.
- It is a high quality benchmarking process aimed at getting the best out of programmes.
- It provides an opportunity for you and your students to influence the society and its support for education providers and students.
- Together we have a powerful voice in raising the profile of psychology and psychological practice in the UK and internationally.

Our standards

In 2017, the Society's Partnership and Accreditation Committee (PAC) and its constituent Education and Training Committees reviewed the overarching programme standards, with the aim of providing greater clarity and more effective signposting to other relevant guidance in a way that is helpful to programmes when they articulate their work.

Our standards are intended to be interpreted and applied flexibly, in a way that enables programmes to develop distinctive identities that make the most of particular strengths shared by their staff team, or those that are reflected in the strategic priorities of their department or university. During partnership visits, the questions that visiting teams will ask will be designed specifically to give education providers every opportunity to confirm their achievement of the standards.

Our standards are organised around eight overarching standards, as follows:



The standards have been derived following extensive consultation between the Society and education providers, and must be achieved by all accredited programmes. Each overarching standard is followed by a rationale for its inclusion, together with guidance and signposting of other relevant resources.

This document

This document sets out the accreditation standards for the accreditation of programmes in clinical psychology. The standards came into operation on 1 October 2017.

If you are submitting a new programme for accreditation, or are preparing for an accreditation visit or review, you should read these standards in conjunction with the relevant process handbook. All handbooks can be downloaded from **www.bps.org.uk/accreditationdownloads**.

Accredited Doctoral programmes meet the requirements for Chartered membership of the Society (CPsychol) and full membership of the Division of Clinical Psychology. Such programmes will seek to prepare trainees for professional practice as a clinical psychologist. Practitioner psychologists are statutorily regulated by the Health and Care Professions Council (HCPC), and it is a legal requirement that anyone who wishes to practise using a title protected by the Health

Professions Order 2001 is on the HCPC's Register. Programmes will also, therefore, need to seek approval from the HCPC.

Preface

The statements in this document form a policy statement by the Society on what accredited programmes should achieve. Programmes should also note the following:

1. The aim of this document is to specify the standards that programmes should achieve. It is not the Society's intention to reduce the diversity between programmes or impair their flexibility to respond to local and changing circumstances. Related to this, the standards often reference indicative, rather than prescriptive, criteria to facilitate this. It is important to emphasise that while the Society expects that the required standards are met, a key emphasis in this document is that wherever possible, the Society does not wish to be prescriptive in how these standards are achieved.
2. Accredited programmes will also need to be approved by the Health and Care Professions Council (HCPC). The HCPC's role is to assure threshold levels of quality, by ensuring that graduates of approved programmes meet the Standards of Proficiency. The Society's accreditation process is designed to work beyond those quality thresholds by promoting quality enhancement.
3. In reading this document, it is essential to recognise that although the various aspects of working as a competent clinical psychologist are described separately, it is the combination and integration of these components that are particularly important. This is true for both the required outcomes of training and for the process of training.
4. In meeting the requirements of a professional training in clinical psychology, programmes should be sufficiently flexible in content and structure to adapt readily to current and future needs and to the emergence of new knowledge in clinical psychology and related fields. They should also play a major part in the identification of such needs and the development of innovative practices. Programmes should refer to the standards and guidelines which are identified and revised from time to time by the Division of Clinical Psychology's Faculties for guidance in relation to the knowledge and skills required for work with specific populations and groups.
5. Programmes will need to work collaboratively with relevant external stakeholders and especially commissioners to identify and negotiate any particular skill sets they may wish to prioritise, and how the standards outlined in this document might best be implemented locally.
6. Education providers may offer two or more programmes in the same branch of applied psychology, and these will be considered as separate programmes.
7. The current accreditation standards have been informed by a number of contemporaneous guidelines and strategy documents. These have included Divisional and Society guidance in relation to knowledge and skills required for work with a wide range of specific populations, the leadership development framework, the Good Practice Guidelines series including those related to formulation, psychological health and wellbeing, connecting communities, codes of conduct and ethical guidelines for practice and research, and working in teams (**www.bpsshop.org.uk**). These guidelines are free to Divisional members.

8. In addition to Society guidelines, these accreditation standards have been informed by:

- Evidence-based practice guidelines such as those as disseminated in NICE/SIGN guidelines on what works for whom (**www.nice.org.uk**; **www.sign.ac.uk**). The Society notes, however, that this guidance is designed to inform, not replace, clinical decision making and such guidance should not be applied in any formulaic fashion – especially pertinent when dealing with the complexity and co-morbidity for which training needs to prepare clinical psychologists. The Society recognises that programmes may wish to be informed by other knowledge bases when developing their curricula – especially where guidelines such as NICE have not been sufficiently developed for given populations or services (e.g. interventions with people with intellectual disability).
- National strategies and policy initiatives related to psychological health and wellbeing. Specific examples are not referenced as rapid change is a feature herein. However, current themes, across the four nations, relate to an increased emphasis on mental health, psychological wellbeing, the talking therapies, improving access, redesign of services, stepped care interventions, diversification of healthcare providers, secondary prevention, psychological interventions in physical healthcare etc. This list is not exhaustive but reflects the contemporaneous influences which have informed the standards review.

Acknowledgements

In preparing the current review of our accreditation standards the Committee for Training in Clinical Psychology was mindful that current standards represent an evolution of such over a great many decades. The values, ethos and tenets which underpin our standards reflect the foresight, intellectual rigour, work and commitment to the profession of clinical psychology of a great many people from our community both current and historical. At this juncture we wish to pay particular tribute to three directors of training programmes who had started this most recent process with us – Malcolm Adams, Andrew Cuthbertson and Mark Rapley. We will remember and thank them for their wisdom, vision and creativity.

The core training of a clinical psychologist: Statement of intent

Clinical psychology is a postgraduate, doctoral, three year training programme which promotes transferable knowledge and competencies relevant to working across a very wide range of health and social care programmes and presentations. These include, for example, services for children, adults, older adults, families, people with developmental and intellectual disability, mild–severe mental health difficulties, physical health presentations, chronic conditions, forensic services, and other groups and presentations which may have been included in a specific training pathway. This is in contrast to multiple, often sub-doctoral, programmes which prepare graduates for work with only circumscribed groups, presentations or models of therapy. As well as safeguarding and improving quality of service provision, the cost-efficiency for commissioning of training is evident.

Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and wellbeing, minimise exclusion and inequalities and enable service users to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure.

The evidence base tells us that different interventions work for different presentations and groups. It also tells us about the central importance of non-specific therapist factors in outcomes. Moreover, service users often present with complex and co-morbid presentations which range from psychological interventions to complex presentations and the specifics of service user contexts. A defining feature of the clinical psychologist is the capacity to draw from, and utilise, different models of therapy, and evidence based interventions, as appropriate to the needs and choices of the service user. The clinical psychologist is not a uni-modal therapist, although by the end of training specific competencies will be professionally accredited by the Society through programme accreditation, within cognitive-behaviour (and one other) model of psychological intervention (which will vary, depending on the training pathway pursued). Many will develop further particular expertise in specific therapies.

The evidence base highlights the relevance of psychological processes, support and interventions across a great many healthcare presentations. Clinical psychologists are trained not just to deliver interventions, but to also promote psychological mindedness and skills in other health, educational and social care providers.

Clinical psychologists as reflective scientist practitioners

Clinical psychology is one of the applications of psychological science to help address human problems. Clinical psychologists have been trained not only to be critical consumers of research, and ever emerging knowledge bases, but to contribute to this knowledge base through research, with relevant skills benchmarked at doctoral level. Clinical psychology has a prominent history of developing, evaluating and refining psychological interventions which are often then promulgated across the skill base of other professions and practitioners.

Complementing this capacity to draw critically from the evidence base to inform their work, clinical psychologists embrace an ethos of practice-based evidence. A critical evaluative stance pervades practice which includes utilising an outcomes framework, informed by wellbeing and recovery principles, as well as the values and goals of the service user. Clinical psychologists will often lead on developing systems of practice-based evidence within services.

Reflective practice is also promoted through an effective use of supervision and collaboration with service users and other colleagues in setting goals and monitoring progress. Importantly, the clinical psychologist will also be aware of the importance of diversity, the social and cultural context of their work, working within an ethical framework, and the need for continuing professional and personal development.

Clinical psychology in practice

Clinical psychologists work with individuals, couples, families and groups and at the organisational and community level. They work in specialist and generic services which increasingly are accessed by groups historically considered as 'specialist'. They work across a diversity of health and social care providers (e.g. NHS, social care, third sector and independent providers and education) and in a variety of settings including in-patient and community, primary, secondary and tertiary care and with all age groups and presentations as noted above.

Overview of the accreditation standards

The standards outlined in this document highlight the training requirements necessary for enabling the graduate clinical psychologist to practice as described in this statement of intent. Whilst the Standards of Proficiency, regulated by the HCPC, assure quality thresholds for safe practice, the accreditation standards outlined here are designed to promote quality enhancement.

Graduates of accredited programmes who have attained these enhanced standards will be eligible for Chartered status through full divisional membership of the Division of Clinical Psychology.

The key features of the accreditation standards include:

- Emphasis on overarching competencies to deliver tailored, multi-modal and often complex, psychological interventions across a range of ages, presentation configurations and service delivery systems and which are informed by knowledge and skills from across formal psychological therapies and other evidence bases.
- Increased credibility that specific knowledge and skills sets, which contribute to the above, have been obtained through transparent benchmarking of work against competence frameworks adapted and appropriate to the age, presentation or specialism to which they are applied.
- Delivering a curriculum which is contemporaneous, relevant to current healthcare exigencies and informed by the evidence base and social contexts.
- Incorporating systematic approaches to in vivo assessment to further quality assure competence development.
- Deepening collaborative practices with service users and carers (including in ways informed by DCP good practice guidance on the involvement of service users and carers in clinical psychology training).
- Greater emphasis on skills of indirect influence and leadership in bringing psychological mindedness to services.

Programme standard 1: Programme design

The design of the programme must ensure that successful achievement of the required learning outcomes is marked by the conferment of an award at the appropriate academic level.

1.1 Credits and level of award: Doctoral programmes seeking accreditation against the requirements for Chartered membership of the Society (CPsychol) must comprise 540 credits, and must result in the award of a level 8 qualification (level 12 in Scotland).

1.2 Duration and location of studies:

1.2.1 For postgraduate professional training programmes in psychology, the **total** period of study must be no less than three years full-time (or the equivalent part-time).

1.2.2 The Society does not stipulate a maximum study period within which an accredited programme must be completed.

1.2.3 Up to one third of the total credits of an accredited UK programme may be undertaken outside of the UK. Where a greater proportion is undertaken abroad, we consider this to be a separate programme requiring separate accreditation.

1.3 Award nomenclature: The education provider must ensure that the title of any award accurately reflects the level of trainees' achievements, represents appropriately the nature and field(s) of study undertaken and is not misleading, either to potential employers or to the general public.

1.4 Assessment requirements:

1.4.1 Programmes must have in place an assessment strategy that maps clearly on to programme and module learning outcomes, incorporates a wide range of formative and summative assessments, and which reflects trainees' development of knowledge and skills as they progress through their studies. Each of the competencies specified in Programme Standard 2, below, must be assessed at the appropriate level.

1.4.2 Accredited postgraduate programmes must stipulate a minimum pass mark of 50 per cent for all modules that contribute to the accredited award where quantified marking is employed. No compensation across modules is permissible.

1.4.3 Programmes must have a clear set of published regulations relating to assessment which are readily accessible and understood by applicants, trainees, staff, supervisors and internal and external examiners. The criteria for passing or failing the programme must be explicit, together with any fall-back awards criteria. These regulations and assessment criteria must relate clearly to the programme's learning outcomes.

1.4.4 Assessment practices should be fair, valid, reliable and appropriate to the level of the award being offered. Assessment should be undertaken only by appropriately qualified staff, who have been adequately trained and briefed, and given regular opportunities to enhance their expertise as assessors.

1.4.5 Programmes should have effective systems in place in order to quality assure, ratify or mediate assessment decisions. This typically involves systems of internal moderation, external examiner review of standards and failure decisions and an exam board which can oversee and, where appropriate, make decisions on pass/fail recommendations.

1.4.6 Programmes must provide written guidelines on criteria for failure in the assessment of all components of the programme. The criteria must be clearly related to the programme's required learning outcomes. In general, the whole period of training should comprise work that is of an acceptable standard. If a trainee has failed an assessment of competence, but been allowed to continue in training, then there must be a clear mechanism for extending the period of training, if necessary, to ensure that there is an opportunity for acceptable standards of practice to be reached and for core competencies to be acquired.

1.4.7 Assessments must give appropriate weighting to professional competence. The Programme Director(s) must take responsibility for ensuring that there are adequate procedures to ensure that trainees who are incompetent or whose behaviour is unethical do not obtain a qualification in clinical psychology. There must also be mechanisms to ensure that such trainees should be identified as early as possible in the programme, and are not allowed to continue if remedial action is ineffective. These procedures should, as far as possible, be consistent across those used by the university and trainees' employers.

1.4.8 Education providers should have in place policies and procedures to deal thoroughly, fairly and expeditiously with problems which arise in the assessment of trainees. Programmes must have an explicit appeals procedure, consistent with university and employers' procedures, for considering formal appeals from trainees who fail to satisfy the examiners. Trainees should be made aware of the process they should follow if they wish to pursue an appeal at the beginning of the programme.

1.4.9 Mechanisms should exist to consider the relevance of extenuating circumstances with respect to decisions about student progression. However, these should not compromise assessment decisions regarding attainment of learning outcomes.

1.5 Inclusive assessment:

1.5.1 Education providers should have inclusive assessment strategies in place that anticipate the diverse needs and abilities of students.

1.5.2 Where reasonable adjustments need to be made for disabled students, these should apply to the process of assessment, and not to the competencies being assessed.

1.6 Assessment procedures:

1.6.1 Education providers should ensure that detailed and up to date records on trainee progress and achievement are kept. Throughout a programme of study, trainees should receive prompt and helpful feedback about their performance in relation to assessment criteria so that they can appropriately direct their subsequent learning activities.

1.6.2 Programmes should use a range of assessment methods, formative and summative, as appropriate to assessing the learning outcomes related to academic knowledge, clinical practice, research competencies and personal and professional development.

1.6.3 In addition to methods of assessment of clinical skills which are based on how the trainee disseminates their work orally and in writing, systematic assessment tools must be in place for evaluating trainees' clinical competencies in vivo. This means that, as part of the assessment of trainees' competence, they should be observed, and the outcome of that observation should contribute to the overall assessment process – either discretely or as part of a larger assessment unit (e.g. placement ratings). Programmes may choose observational assessment tools or protocols that are most appropriate for their context. How these are applied may also vary and some possible examples of application are provided below:

- supervisor or programme staff observation and assessment of clinical practice (e.g. psychometric and other approaches to assessment, intervention);
- supervisor or programme staff observation of simulations related to the above (e.g. role plays involving service users, colleagues or actors);
- supervisor or programme staff assessment of recordings of practice (audio or video) and/or transcriptions of the same.
- supervisor or programme staff observation and assessment of non-therapy skills (e.g. performance in multidisciplinary team, presentations, training).

1.6.4 In addition to observation and assessment by supervisors or programme staff, programmes are also encouraged to work with service user and carer colleagues to design ways in which their feedback may be incorporated into the assessment process.

Rationale for inclusion

The Society has clear expectations about teaching, learning and assessment on accredited programmes, and the provisions that should be built into the design of those programmes to ensure quality. The standards outlined above will ensure that those seeking entry to specific grades of Society membership on the basis of having completed an accredited programme have met the stipulations set out in the Society's *Royal Charter, Statutes and Rules*.

Guidance and signposting

- Part A of the UK Quality Code addresses Setting and Maintaining Academic Standards, and signposts relevant qualifications and credit frameworks, as well as guidance on the characteristics of different qualifications. Providers may also find it helpful to refer to a further five chapters from Part B of the Quality Code (**www.qaa.ac.uk**):
    - Chapter B1: Programme Design, Development and Approval
    - Chapter B3: Learning and Teaching
    - Chapter B6: Assessment of Students and the Recognition of Prior Learning
    - Chapter B9: Academic Appeals and Student Complaints
    - Chapter B11: Research Degrees
- The Health and Care Professions Council sets out its requirements around programme design and delivery and assessment in its Standards of Education and Training (SETs 4 and 6; **www.hcpc-uk.org/education**). Information on the threshold level of qualification for entry to the HCPC Register is provided in SET 1.
- The Society's standards require that all accredited stage one MSc and Doctoral programmes stipulate a minimum 50 per cent pass mark for all modules that contribute to the accredited award. Some providers operate a standard 40 per cent pass mark for their postgraduate programmes; accredited programmes will need to seek variation from

the provider's standard regulations in order to meet this requirement. Graduates who do not achieve the necessary 50 per cent pass mark for all modules contributing to the accredited degree should receive an alternative award to enable them to be distinguished from those who have achieved the expected standard.

- The Equality Challenge Unit has produced guidance on Managing Reasonable Adjustments in Higher Education, which providers may find helpful (**www.ecu.ac.uk**).
- The Society's accreditation standards make provision for trainees to undertake some study or placement time abroad as part of their programme (up to one third of the total credits of the accredited programme). Study abroad opportunities may not be available for all trainees, and arrangements will vary across different providers. Where study abroad opportunities are available, the UK provider must ensure that the study abroad being undertaken allows trainees to cover all of the required curriculum and competencies appropriately by the time they have completed their programme (though not necessarily in the same way as others on their cohort), and that this learning will effectively support their progression. More detailed information is available in our guide to studying abroad on an accredited programme, which can be downloaded from **www.bps.org.uk/internationalaccreditation**.
- Where more than one third of the total credits for the programme are undertaken outside of the UK, the Society considers this to be a separate programme requiring separate accreditation. Information regarding the Society's international accreditation process can be found at **www.bps.org.uk/internationalaccreditation**.
- The Society does not specify a maximum study period for an accredited programme. It is expected that individual education providers will have in place regulations governing the maximum permissible period of time that may elapse from initial enrolment to completion, regardless of individual circumstances, to ensure the currency of their knowledge, their competence, and the award conferred upon them.

Programme standard 2: Programme content (learning, research and practice)

The programme must reflect contemporary learning, research and practice in psychology.

2.1 Programme content requirements

2.1.1 Clinical psychology programmes will vary in the emphases they place on work with particular clinical groups, therapeutic modalities, curriculum content, non-therapy skills, training methods etc. This is healthy and promotes diversity and richness within the profession. It ensures programmes can be responsive to regional and national priorities, opens up opportunities for some programmes to coordinate and complement their efforts and offers prospective applicants choice of programmes which best suit their own preferences, learning style and goals. Similarly, trainee clinical psychologists within programmes may follow a range of training pathways depending on practice placement experiences, research undertaken, optional modules chosen etc. Thus whilst all graduates will demonstrate core standards of proficiency, with transferability demonstrated across the range of clients and services as specified below, some variation in individual strengths and competencies will be both inevitable and desirable.

This context means that whilst the BPS will accredit programmes as meeting the standards required for their graduates to be eligible for Chartered status, it will be incumbent on programmes to validate the specific portfolio of skills and competencies of graduates in a way which is transparent to employers and commissioners of services. Whilst programmes are free to develop their own portfolio format, examples of how this might look are contained in Appendix 1. These examples should be seen as indicative, rather than prescriptive.

2.1.2 Overarching goals, outcomes, ethos and values for all programmes include the following:

By the end of their programme, trainees will have:

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological wellbeing through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.
2. The skills, knowledge and values to develop *working alliances* with clients, including individuals, carers and/or services, in order to carry out *psychological assessment*, develop a *formulation* based on psychological theories and knowledge, carry out *psychological interventions*, *evaluate* their work and *communicate* effectively with clients, referrers and others, orally, electronically and in writing.
3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.
4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact

of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.

5. Clinical and research skills that demonstrate work with clients and systems based on a *reflective scientist-practitioner* model that incorporates a cycle of assessment, formulation, intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.

6. The skills, knowledge and values to work effectively with *systems* relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.

7. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare. This includes leadership skills and competencies in *consultancy*, *supervision*, *teaching* and *training*, working collaboratively and *influencing psychological mindedness* and *practices of teams*.

8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.

9. A professional and ethical value base, including that set out in the BPS *Code of Ethics and Conduct*, the *DCP statement of the Core Purpose and Philosophy* of the profession and the *DCP Professional Practice Guidelines*.

10. High level skills in managing a *personal learning agenda* and self-care, in *critical reflection* and *self-awareness* that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues.

2.1.3 NINE core competencies are defined as follows:

1. Generalisable meta-competencies

- **a.** Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations and communities.
- **b.** Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to work effectively whilst holding in mind alternative, competing explanations.
- **c.** Generalising and synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.
- **d.** Being familiar with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision-making without being formulaic in application.

- **e.** Complementing evidence-based practice with an ethos of practice-based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.
- **f.** Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.
- **g.** Making informed judgments on complex issues in specialist fields, often in the absence of complete information.
- **h.** Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.
- **i.** Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity, and working as a reflective practitioner within ethical and professional practice frameworks.

2. Psychological assessment

- **a.** Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.
- **b.** 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.
- **c.** Assessment procedures in which competence is demonstrated will include:
  - performance based psychometric measures (e.g. of cognition and development);
  - self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours);
  - systematic interviewing procedures;
  - other structured methods of assessment (e.g. observation, or gathering information from others); and
  - assessment of social context and organisations.
- **d.** Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.
- **e.** Conducting appropriate risk assessment and using this to guide practice.

3. Psychological formulation

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

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

c. Constructing formulations utilising theoretical frameworks with an integrative, multimodel, perspective as appropriate and adapted to circumstance and context.

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

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

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

g. Ensuring that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

h. Using formulations to guide appropriate interventions if appropriate.

i. Reflecting on and revising formulations in the light of ongoing feedback and intervention.

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

4. Psychological intervention

a. 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

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

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

- **d.** In addition, however, the ability to utilise multi-model interventions, as appropriate to the complexity and/or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.
- **e.** Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and wellbeing.
- **f.** Conducting interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals.
- **g.** Having an awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.
- **h.** Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives.
- **i.** Implementing interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.
- **j.** Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to clients and carers.

5. Evaluation

- **a.** Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).
- **b.** Devising innovate evaluative procedures where appropriate.
- **c.** Capacity to utilise supervision effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.
- **d.** Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.
- **e.** Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.
- **f.** Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

6. Research

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

b. Conceptualising, designing and conducting independent, original and translational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and merit publication including: identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis (both quantitative and qualitative), reporting outcomes and identifying appropriate pathways for dissemination.

c. Understanding the need and value of undertaking translational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.

d. The capacity to conduct service evaluation, small N, pilot and feasibility studies and other research which is consistent with the values of both evidence-based practice and practice-based evidence.

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

7. Personal and professional skills and values

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

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

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

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

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

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

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

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

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

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

8. Communication and teaching

- **a.** 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).
- **b.** Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.
- **c.** Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).
- **d.** Understanding of the supervision process for both supervisee and supervisor roles.
- **e.** Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.
- **f.** Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof.
- **g.** Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

9. Organisational and systemic influence and leadership

- **a.** Awareness of the legislative and national planning contexts for service delivery and clinical practice.
- **b.** Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.
- **c.** Providing supervision at an appropriate level within own sphere of competence.
- **d.** Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.
- **e.** Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.
- **f.** Working with users and carers to facilitate their involvement in service planning and delivery.
- **g.** Understanding of change processes in service delivery systems.

h. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.

i. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

2.1.4 The structure of training

1. It is essential that programmes provide a holistic experience of training that enables trainees to develop an integrated set of learning outcomes.
2. Programmes should provide a balanced and developmental set of academic, research and clinical experiences throughout training. The academic component needs to provide an integrated curriculum supporting the clinical and research training. The research training needs to be carefully planned and have sufficient time devoted to it to enable trainees to conduct research at a postgraduate level and to be in a position to contribute to the knowledge base of the profession.
3. Supervised practice needs to be gained across the range of clients, therapy and intervention modalities and settings as outlined below (section 2.4.1). Clinical experience will be gained in service delivery systems that offer a coherent clinical context. This can include settings defined for the purposes of training by one, or a combination of, factor(s) including the population (e.g. child, adult, older people), special needs (e.g. intellectual disability, serious mental health problems, health-related problems, substance abuse), psychological interventions (e.g. model of therapy) or service delivery contexts (e.g. primary, secondary and tertiary care, in-patient, out-patient, community, third sector, leadership, consultancy or inter-professional working).
4. A hallmark and strength of clinical psychology training is that generalisable and transferrable skills and competencies are developed. This is evidenced by demonstration of the core competencies outlined in 2.1.3 above and across the settings outlined in 2.4.1 below. However, it would be impossible to demonstrate these competencies across ALL such settings, and combination of settings, and thus, once again, these are indicative rather than prescriptive. Moreover, programmes generally, and individual trainees specifically, will vary in emphases and strengths. A sufficient range of experience must be attained, however, to evidence this transferability in practice. Thus, the *specific* settings, population and interventions in which competencies have been demonstrated must be monitored and available within a training portfolio (see Appendix 1 for an example of how such a portfolio might look).
5. It is important to recognise that the scope of clinical psychology is so great that initial training provides a foundation for the range of skills and knowledge demonstrated by the profession. Further skills and knowledge will need to be acquired through continuing professional development appropriate to the specific employment pathways taken by newly qualified psychologists.

6. Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the health and social care sectors. These requirements will be shaped in part by national policies and service frameworks, as well as by evidence of recruitment problems in specialties or regions. National standards as set out by the Division of Clinical Psychology's Faculties should guide training patterns for each cohort of trainees and programmes should consult with these and other local stakeholders to ensure that – across the trainee cohort – there is optimum, effective and efficient use of all available placements.
7. Of the total programme time (exclusive of annual leave), at least fifty per cent must be allocated to supervised clinical experience. In addition, at least ten per cent must be available to trainees for self-directed study throughout the programme. Of the remaining time there must be an appropriate balance between research activity and learning and teaching, to ensure that the guidance outlined in sections 2.2 and 2.3 below can be met.

2.2. Teaching and learning:

2.2.1 A clear programme specification must be in place that provides a concise description of the intended learning outcomes of the programme, and which helps trainees to understand the teaching and learning methods that enable the learning outcomes to be achieved, and the assessment methods that enable achievement to be demonstrated with adequate breadth and depth. The programme specification (and any module specifications) must include learning outcomes that reflect the specific programme content requirements outlined above.

2.2.2 Education providers must be able to document the intended programme and module learning outcomes, and the ways in which these are mapped on to the programme content requirements outlined above.

2.2.3 Programmes must have a statement of orientation and values that underlie their programme specification. In addition to articulating learning outcomes and an assessment strategy that reflect the competencies outlined in this handbook, programmes must be able to show how their orientation and values inform their teaching and learning strategy.

2.2.4 Trainees are entitled to expect a learning experience which meets their needs, and which is underpinned by competent, research-informed teaching, and a supportive and enabling learning environment.

2.2.5 Programmes must meet the following specific curriculum requirements:

1. Programmes should have an academic syllabus and a coherent plan for organising and presenting the material to be covered. The academic syllabus and plan will reflect the programme specification and will be designed to help trainees achieve the learning outcomes set out in 2.1 above. The content of curricula should reflect relevant and up to date psychological knowledge and skills, ensuring that contemporary psychological practice and research is promoted. Programmes should be able to demonstrate how the syllabus has been informed by general and specific guidance such as: DCP policy (including Faculty good practice

guidelines); recognised practice guidance such as NICE/SIGN where this exists, and other sources relevant to the practice of clinical psychology and its advancing knowledge base.

2. It is recognised that programmes may legitimately vary in their curricular emphases, taxonomical system and language for defining presentations. Programmes should be mindful of the DCP position statement regarding limitations in ‘diagnostic’ frameworks and this may inform language and taxonomy. However, to a greater or lesser degree the indicative areas of curriculum content specified in this document, have been informed by commonly used taxonomies as understood not only by the profession, but by service users, carers, commissioners, colleagues and other stakeholders.

3. Indicative content for a clinical psychology curriculum should reflect a broad range of conditions and interventions that includes the following:

  a. A satisfactory introductory programme that addresses practical issues and is geared to familiarising the trainee with skills in engaging clients, working collaboratively, assessment methods, including interviewing, observational techniques and psychometric assessment.

  b. Clinical psychology in context including our history and the evolution of healthcare systems in the UK.

  c. Knowledge and theories related to the psychological needs and problems of a range of client groups across the lifespan and relevant to clinical psychology. In practice this should relate to:

  - common mental health presentations (e.g. anxiety presentations and depression);
  - severe and enduring mental health presentations (e.g. hearing voices, psychosis, complex trauma);
  - physical health presentations and issues related to adjustment and coping across the lifespan;
  - presentations of infancy and childhood (e.g. infant mental health, developmental, social, adjustment to adversity, physical health presentations, looked after children, conduct and mood difficulties);
  - presentations of older adulthood (e.g. related to developmental changes and psychosocial adaptation, losses to cognitive functioning);
  - neurological presentations of adult and childhood;
  - presentations of those with physical and intellectual disability;
  - specialist clinical presentations which could present across the lifespan and in combination with other presentations such as substance misuse, addictive behaviours, eating disorders, personality disorders and forensic presentations.

  In practice trainees will often work with complex and co-morbid presentations and thus will be required to synthesise the relevance of any single presentation knowledge base for transtheoretical application.

  d. Substantial teaching on the theory and practice of psychological assessment methods, including the interpretation of findings and the formulation of clinical problems. There should be explicit consideration of the relationship between assessment, formulation, intervention and evaluation. This should be in relation to service users across the age range, with the range of presentations and as underpinned by the different therapeutic modalities as specified in 2.4.1 below.

- **e.** Understanding of the theoretical and evidence bases related to commonly used psychometric assessments. Psychometric theory and approaches to understanding assessment findings including statistical and clinical significance should be understood.
- **f.** Substantial coverage of formal systems of psychological interventions and this must include more than one orientation and approach. Content should include the philosophical and theoretical bases of therapies, their practical application to various client groups, and their current empirical status. Consideration should be given to the evidence base of what works for whom and when it is appropriate to draw from different knowledge bases, especially in work with complex and co-morbid presentations.
- **g.** Opportunities for learning about professional and organisational issues. This should include the organisation of health and social care services and the profession, and the work of related professions and agencies. The Society's *Code of Ethics and Conduct* should be covered together with emergent ethical competence frameworks for applied psychology, as well as the impact of major legislative frameworks, statutory regulation, and other significant developments affecting the profession.
- **h.** Issues concerning the influences of society, cultural and other areas of diversity should be integrated throughout the academic programme, demonstrating the relevance to clinical practice. Values related to an ethos of critical community psychology, recovery and wellbeing should inform appropriate aspects of the curriculum.
- **i.** Non-therapy skills such as exerting influence and leadership, critical self-awareness, communication and teaching, models of consultancy, multidisciplinary working and group and organisational processes.
- **j.** Programmes should be responsive to new developments and areas of concern within the profession and aim to incorporate learning opportunities in such areas within the programme as and when appropriate.

4. The plan for delivering the academic syllabus must ensure that trainees receive adequate preparation for their clinical placements and that there are adequate links between the taught material and contemporaneous placements. This will mean that the plan takes account of the likelihood that trainees in the same cohort will be working in different clinical specialties at any one time.

5. Programmes should provide substantial learning opportunities that use a range of educational methods, adapting the style of these to the stage a trainee has reached. In general, methods should be used which require substantial trainee participation.

6. The majority of the learning opportunities should be provided by clinically qualified psychologists. However, service users and carers should inform and participate in the delivery of the curriculum. Teaching by other psychologists and professionals is to be encouraged as is engagement with inter-professional learning.

2.3 Research:

2.3.1 Programmes must have an explicit and written statement of aims and objectives for a programme of research training throughout the programme. This should be developed in discussion with supervisors and should include the aim of encouraging clinical research during placements. Where appropriate, collaborative research should be encouraged.

2.3.2 Programmes should provide sound teaching and training in research methodology. This will include:

- formal teaching of research design and methods including small N designs, pilot and feasibility studies and those methods, both quantitative and qualitative, that are most useful in the conduct of applicable clinical research including service evaluation;
- ethical issues in research;
- statistical analysis including both exploratory and hypothesis testing methods;
- critical appraisal of published research including systematic reviews, and
- supervised research work involving not only a major project but also some smaller scale service related research or research related to professional issues.

The Society has published *Supplementary guidance for research and research methods on Society accredited postgraduate programmes*, and providers must be able to demonstrate how they have taken account of these guidelines in designing, developing and delivering their research methods and project provision.

2.3.3 Trainees must complete at least one formally assessed smaller scale project involving the use of audit, service development, service evaluation or applied research methods related to service delivery or professional issues.

2.3.4 During the programme trainees must undertake an independent research project that requires them to conceptualise, design, carry out and communicate the results of research that is relevant to clinical psychology theory and practice. Research methodologies and traditions are not prescribed and programmes and examiners should take an inclusive approach to acceptable products. However, this research should be at doctoral level, merit publication through a peer–reviewed process and contribute to the knowledge base related to clinical psychology.

2.3.5 All research projects must demonstrate that they conform to the appropriate relevant ethics and governance procedures and to the Society's guidelines on the conduct of research.

2.3.6 Trainees must have access to computer facilities for data analysis and have adequate training in their use, including guidance on data protection and confidentiality.

2.3.7 Each trainee must have a research supervisor who is competent in research supervision. The Programme Director or research coordinator must be responsible for approving the allocation of research supervisors. Supervisory loads must be monitored and be such that adequate supervision is provided to trainees. There should be a research agreement between supervisor and trainee that covers matters such as a schedule of regular supervision meetings and progress reviews, written feedback on drafts and a timetable for the project.

2.3.8 Great care must be taken to allow trainees to plan and organise their research project in good time, such that there is the opportunity to complete it successfully. Time must be set aside early on in the programme for discussion of the proposed project. Regular monitoring of trainees' progress and the quality of the research must be carried out throughout the programme.

2.3.9 Programmes must be sensitive to the problems that may arise in carrying out applied research. Care must be taken to anticipate common difficulties and take preventative action.

2.3.10 The research curriculum must be designed to promote post-qualification practice that includes research activity through conducting and facilitating research, and applying research to inform practice.

2.4 Supervised practice:

2.4.1 Clinical experience and skills:

Programmes must ensure that trainees gain the following clinical experience and skills:

1. The learning outcomes described above need to be demonstrated with a range of clients and across a range of settings. In keeping with the spirit of these standards, these outcomes are not defined prescriptively, and there are multiple pathways through which these goals may be achieved. The range of service user presentations and settings is outlined below and these experiences should be supported by the curriculum exposure as outlined in 2.2 above to promote the competencies defined in 2.1.3.

2. **Service Users:** A fundamental principle is that trainees work with clients across the lifespan, such that they see a range of service users whose difficulties are representative of problems across all stages of development. These include:

- a wide breadth of presentations – from acute to enduring and from mild to severe;
- problems ranging from those with mainly biological and/or neuropsychological causation to those emanating mainly from psychosocial factors;
- problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions;
- service users with significant levels of challenging behaviour;
- service users across a range of levels of intellectual functioning over a range of ages, specifically to include experience with individuals with developmental intellectual disability and acquired cognitive impairment;
- service users whose disability makes it difficult for them to communicate;
- where service users include carers and families;
- service users from a range of backgrounds reflecting the demographic characteristics of the population. Trainees will need to understand the impact of difference and diversity on people's lives (including sexuality, disability,

ethnicity, culture, faith, cohort differences of age, socio-economic status), and their implications for working practices.

3. **Service delivery systems:** Trainees should have experience of working across a range of healthcare systems and providers. These could be largely within the NHS but may also involve work within third sector, social care, and independent providers encompassing primary and community care, secondary care and in-patient or other residential facilities. The extent to which such placements are used will be dependent on local circumstances.

4. **Modes and type of work:** Trainees should:
    - undertake assessment, formulation and intervention both directly and indirectly (e.g. through staff, carers and consulting with other professionals delivering care and intervention);
    - this work should be underpinned by at least two evidence-based models of formal psychological intervention, one of which must be cognitive-behaviour therapy;
    - however, trainees must be able to work with complexity and co-morbidity and thus draw from knowledge bases across models of therapy, and evidence bases for different interventions and approaches, when appropriate to the needs and choices of the service user;
    - work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;
    - be critical of their own approach, and aware of how to practise in the absence of reliable evidence, as well as being able to contribute from their work to the evidence base.

5. Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken.

6. The national standards as set out by the Division of Clinical Psychology's Faculties should provide reference information for supervised practice commensurate with competence in a given area of work. Based on this reference information programmes will develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. The degree to which programmes privilege particular faculty guidance is one way in which specific programme strengths and identity will emerge.

7. The length of time in a placement, the number of, and the length of time involved with, service users must be sufficient to allow this. An adequate balance of time must be allocated across services and client groups, and optimum use made of available placements, so that the required range of experience across the lifespan may be gained.

8. The programme of supervised clinical experience needs to be planned for each trainee in order to ensure that all trainees will gain required experience. The Programme Director or Clinical coordinator is responsible for monitoring each individual plan and making adjustments as necessary so that any gaps or problems can be identified early and resolved later in training. The main requirement is that over the period of the programme trainees must gain the

range of experience noted above, rather than spending specified lengths of time in particular placements. Flexibility in placement planning is needed to ensure this. Trainees must be fully involved in monitoring their individual plan.

9. Programmes should ensure that within clinical placements trainees have experience of working with other professions, and that the opportunities for inter-professional learning are maximised.

10. Trainees must keep a portfolio of their clinical experience to enable their training plan to be monitored and to evidence the range of presentations, service delivery systems, modes of working etc. in which competencies have been accrued.

11. The portfolio must clearly summarise the experiences and work undertaken within a given placement setting and cumulatively across training. Whilst it is expected that the competencies outlined in section 2.1.3 related to the transferrable skills of assessment, formulation, intervention and evaluation will be integral to most placements, the specific service user presentations, service settings and modes of working will vary and need to be defined and summarised in a readily accessible and transparent way. Whilst a template example is presented in Appendix 1, programmes are encouraged to develop their own portfolio system.

12. In addition, programmes must operationalise their requirements for trainees to demonstrate competence in the two specific models of psychological therapy required (one of which must be cognitive behaviour therapy) in a credible and robust way. The Society recognises that there is no patent on defining these and that individual training programmes and trainees will vary in the breadth and level of competence promoted. However, the Society will accredit programmes in so far as they have operationalised their own minimum standards for individual validation. These should be benchmarked against recognised criteria, where these exist, such as those formulated by the Society's Centre for Outcomes Research and Effectiveness (CORE). However, programmes may adapt these, or indeed use other credible competence frameworks, which best capture the application of CBT and other therapies to specific ages, populations and presentations. A template example of how these might look is presented in Appendix 1.

13. Similar requirements for test competencies should be operationalised as outlined in 2.5.2 below.

2.4.2 Clinical supervision:

Programmes must ensure that trainees' clinical supervision meets the following standards:

1. Programmes must have access to an adequate number of appropriately qualified and experienced placement supervisors.

2. Trainees will have a co-ordinating placement tutor or supervisor who is a qualified clinical psychologist. The identification of a co-ordinating tutor or supervisor is intended to ensure that the trainee participates in supervision with an appropriately qualified psychologist for the majority of their training. The co-ordinating supervisor may be a member of the programme team.

3. In addition, trainees will have clinical or practice supervisors. These supervisors must be appropriately qualified, but may be registered in a different domain of psychology, or be a member of another profession:
   - Psychologists providing supervision to trainees on accredited programmes must be registered with the Health and Care Professions Council.
   - Members of other professions who are providing supervision to trainees on accredited programmes should normally be registered with an appropriate professional or statutory body.

   The nature of supervision provided will depend on the organisational context in which the placement takes place and may range from supervision of specific case work to supervision of the whole placement experience. It is for programmes to ensure that all supervisors, based on their training, experience and CPD, have the appropriate competencies to be offering the particular services in which they are supervising the trainee.
4. All supervisors are expected to have completed training in supervision as recognised by the Society or provided by the education provider.
5. All clinical supervisors must be fully aware of their responsibilities. No placement should be arranged unless the supervisor has indicated her or his willingness to provide full supervision and take responsibility for the trainee. The programme must have written guidelines on clinical supervision, or, alternatively, utilise the Society's guidelines, which are available at **www.bps.org.uk/accreditationdownloads**. The guidelines on supervision must be circulated to all supervisors.
6. 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:
   - **a.** that each trainee has a named supervisor who is responsible for the co-ordination of their supervision and who formally assesses the trainee in consultation with the other supervisor(s) involved; and
   - **b.** that individual supervision provides opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as ongoing case work.
7. Supervision in all placements must meet the following standards:
   - **a.** The general aims of the placement should be established prior to or at the very beginning of the placement. These should make explicit reference to these training standards, and the specific competencies that need to be developed must have been mutually agreed in person to ensure that expectations can be clearly set and communicated on all sides.
   - **b.** A written placement contract should be drawn up towards the start of the placement. The contract should outline the amount, frequency and nature of the supervision that will take place as well as any planned interaction between the three parties involved (programme-trainee, placement-trainee, placement-programme) for the purposes of placement monitoring.

   - **c.** There must be a formal, scheduled supervision meeting each week that must be of at least an hour's duration. Supervision should normally take place on a face-to-face basis, although education providers may specify within the contract any circumstances under which alternative arrangements may be put in place. The supervision required may differ depending on the stage of development of the trainee and any specific learning needs that may have been identified.
   - **d.** The trainee must have an appropriate amount of individual supervision in addition to any group supervision.
   - **e.** Total 'contact' time between supervisor(s) and trainee(s) must be at least three hours per week.
   - **f.** There must be a formal, interim review of the trainee's progress in the placement, and of the experience provided.
   - **g.** Full written feedback should be given on the trainee's performance on placements.
   - **h.** The trainee must see and comment on the full report.
   - **i.** Trainees must have the opportunity to observe the work of their supervisors; supervisors must observe the work of trainees.
   - **j.** Supervisors should be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work.
   - **k.** Supervisors should closely monitor and help develop trainees' communications (oral and written) and non-therapy skills as defined above.

8. There must be a formal process whereby the programme team monitors the clinical experience of trainees and the supervision provided, and helps to resolve any problems that may have arisen. This process must be timed such that if there are problems there will be still be time available in the placement to overcome the problems, if this is feasible. The process must include the opportunity for a member of the programme team to hold discussions in private with the trainee and supervisor individually prior to a joint discussion. A written record of the monitoring and any action plan agreed must be held on file.

9. Regular workshops on supervisory skills and other training events for supervisors must be organised by the programme to ensure effective supervision. Supervisors should attend workshops and training events periodically. Programmes must ensure that the training events offered meet the needs of both new supervisors and more experienced colleagues. Suggested learning objectives for introductory supervisor training are provided at **www.bps.org.uk/accreditationdownloads**.

10. Trainees must have the opportunity to provide feedback on the adequacy of placements and supervision, and programmes should ensure that it is possible to change important aspects of placements that are found to be unsatisfactory.

11. Programmes must have a formal, documented audit process for clinical placements and supervision in partnership with Heads of Service and supervisors. The Programme Board/Training Committee must have mechanisms for considering the outcomes of each audit, and procedures for seeking to overcome any problems that are identified.

2.4.3 Critical evidence-based practice:

1. During the periods when trainees are on clinical placements, supervisors should guide trainees to read relevant literature and use their knowledge of the literature to inform their clinical work, particularly formulation of clinical problems.
2. It is important that supervisors and programme staff keep abreast of theoretical, research and evidence-based guidance in their fields of work, and participate in continuing professional development. It is important that trainees are encouraged to develop a critically reflective stance to the evidence base and do not seek to apply it in a reductionistic and formulaic fashion.
3. During the academic programme, teachers should be encouraged to use clinical material of their own and of the trainees as a means of elucidating theoretical and research issues.
4. Programmes must consider how they integrate theory and practice throughout the clinical training programme. This should include consideration of issues such as the use of academic knowledge on placement, the use of clinical examples in teaching and how the academic programme as a whole relates to the clinical experience.
5. Since trainees may not all follow the same pathway through training, programmes should have a system for monitoring the level of integration that is achieved between academic teaching and placement training and for developing an action plan to deal with problems.

2.5 Transparency in validating specific competencies:

The hallmark features of training in clinical psychology have been highlighted in the statement of intent at the beginning of this document. These include the capacity to draw from knowledge across the evidence bases of psychological therapies and interventions of what works for whom, and applying that in a critical way to common, as well as complex and co-morbid presentations. The ability to draw across knowledge of different models is key to being able to select the best intervention(s) for the client but this should not be taken to imply that uni-model interventions cannot offer the best approach for a particular client. However, it does indicate that clinical psychologists need to be able to conceptualise in both a uni-model and a multi-model way. The capacity to transfer these competencies across specialisms and populations, service delivery systems and across the lifespan is a defining feature of clinical psychology training. Moreover, the research skills to be effective consumers, but also contributors to the knowledge base, are emphasised. Procedures to achieve these doctoral level competencies underpin current accreditation standards to confer Chartered status with full divisional membership.

However, the Society recognises that some specific employment competencies, which whilst encompassed in clinical psychology training and accreditation standards, are not unique to the training of clinical psychologists. In particular these include competence to deliver specific therapies (i.e. cognitive behaviour therapy plus one other) and test competencies.

2.5.1 Consequently, and in order to facilitate employer and commissioner appreciation of these specific competencies programmes should benchmark their curriculum and placement provision against a competence framework in whichever formal models of psychological intervention they are including in relation to the criteria outlined in 2.1.3 (4) and 2.4.1 (4) above.

a. It should be clear from this exercise that programmes have in place an academic curriculum, placement and supervisory resources required to meet a given competence framework for all trainees, in terms of CBT. Similarly, curriculum, placement and supervisory resources should be in place for the second model of psychological intervention, which will either be agreed by the programme for all trainees, or selected by the trainee in a specific training pathway (thus the second model may vary across trainees within a single programme).

b. The Society recognises that therapy competence frameworks may be operationalised and defined in different ways. The Society would encourage using the competence frameworks developed by the BPS Centre for Outcomes Research and Effectiveness (CORE), as a starting point. These may be utilised as they stand, or programmes may adapt these to make them more relevant to applying (for example) CBT to work outside adult mental health (e.g. with children, people with an intellectual disability, people who hear voices, older adults etc.). The same principle is relevant to the other therapy frameworks. The generic competencies within each competence framework are key here, though programmes are free to formulate competence frameworks for specific presentations if, for example, that is consistent with how they choose to market and define themselves. Programmes may utilise other competence frameworks where appropriate to the skills they say their trainee(s) are competent within. The key principle is that programmes utilise a credible competence framework to quality assure trainee work against. The Society will accredit programmes where this is the case, although the more widely accepted a competence framework is, the more credible these learning outcomes are likely to be in the employment and commissioning market.

c. The Society will accredit a programme as having the required curriculum, placement and supervisory resources required to enable trainees to meet these competencies in principle should the trainee choose a particular placement pathway to obtain these. It should be noted that the Society does not require supervisors to be ‘accredited’ by any other professional body to supervise specific therapies, though this may of course be the case. Rather, it is the capacity to utilise specific therapy interventions in the practice of clinical psychology which is key and we would expect programmes to have in place ways of identifying supervisors and placements where this is the case.

d. It will thus be incumbent on programmes to have in place monitoring and assessment systems to validate the attainment of competencies in their trainees as specific intervention subsets are likely to vary depending on programme emphases and indeed the placement pathway pursued by individual trainees. In addition to the programme benchmarking the curriculum, trainees are thus required to keep portfolios of clinical experience, certified by their supervisors, which attests to the achievement of given competencies within a competence framework (e.g. use of behavioural activation, circular questioning, guided discovery, working with transference etc.) across clinical activities. These could be obtained in many placement settings and with varied populations and should not necessarily be required within a uni-modal CBT, or psychodynamic, or systemic placement etc. – although again this would also be satisfactory. A template example of how such a system might look in the clinical practice portfolio is outlined in Appendix 1.

2.5.2 Similar principles should operate in accreditation of a programmes capacity to promote test competencies. The fundamental feature of the competencies defined in 2.1.3 (2 and 5) above is that trainees should be able to choose, use and interpret tests and test results. The curriculum and placement experiences should clearly highlight how these competencies are promoted. Programmes may find the DCP publication on test standards in clinical psychology training (2009) and the more recent competence framework developed by the Division of Neuropsychology (2012) useful in guiding thinking here. Similarly, the clinical portfolio should make clear in which tests (performance and paper and pencil psychometrics) the trainee has experience. Sufficient exposure should be attained to allow generalisability to be inferred and some, at least formative, *in vivo* assessment should pertain here.

Rationale for inclusion

The Society's standards for accredited programmes reflect contemporary theory, research and practice, enabling accredited programmes to develop psychologists who will be fit for purpose for the future. As such, these reflect the optimal academic and professional standards, promoted by the Society through the award of Graduate membership (MBPsS) and the Graduate Basis for Chartered membership (GBC), and Chartered membership (CPsychol) respectively. The Society is keen that these standards create flexibility for programmes to develop distinctive identities, by making the most of particular strengths around research and practice shared by their staff team, or those that are reflected in the strategic priorities of their department or university.

Guidance and signposting

- Education providers are free to map topics in any academically coherent combination, which could range from delivering core content areas within dedicated modules, or embedding coverage across a number of modules. The Society encourages programmes to deliver core content across modules within an integrated curriculum that offers a pedagogical development of trainees' knowledge, understanding, and skills.
- Providers may find it helpful to refer to Chapter B3 of the UK Quality Code, which addresses Learning and Teaching (**www.qaa.ac.uk**).
- The Health and Care Professions Council sets out its requirements around programme design and delivery (including curriculum guidance) and practice-based learning in its Standards of Education and Training (SETs 4 and 5; **www.hcpc-uk.org/education**).
- The Society has produced *Supplementary guidelines for research and research methods on Society accredited postgraduate programmes* (revised April 2017). A further document, *Supplementary guidelines for research and research methods on Society accredited undergraduate and conversion programmes*, was also published in April 2017.

Programme standard 3: Working ethically and legally

The programme must evaluate trainees' understanding of working ethically and legally.

3.1 All accredited programmes must include teaching on the Society's *Code of Ethics and Conduct* and relevant supplementary ethical guidelines.

3.2 Accredited programmes must have mechanisms in place to ensure that all research undertaken by trainees that involves human participants is conducted in line with the Society's *Code of Human Research Ethics*.

3.3 Programmes must ensure that trainees are taught and assessed on ethics beyond the submission of ethics applications for research projects.

3.4 Programmes should familiarise trainees with the distinct role of the Society as the professional body for psychology, and the Health and Care Professions Council as the statutory regulator for practitioner psychologists in the UK. Programmes should ensure that trainees are aware of the legal and statutory obligations and restrictions on the practice of psychology in the UK context.

3.5 Master's and Doctoral programmes are also expected to make trainees aware of the Health and Care Professions Council's *Guidance on Conduct and Ethics for Students*.

Rationale for inclusion

The inclusion of this standard reflects the particular importance of ethics and ethical practice to psychologists, and to the Society as the professional body for psychology and psychological practitioners. Students and trainees on accredited programmes need to be able to: identify the presence of an ethical issue (ethical sensitivity); formulate the morally ideal course of action by identifying the relevant ethical issues and using these principles to consider appropriate actions (ethical reasoning); decide what they wish and intend to do (ethical motivation); and execute and implement what they intend to do (ethical implementation). They also need to develop commitment to the ethical principles of respect, competence, responsibility, and integrity – as appropriate to their level of study. In addition, all prospective psychologists and psychological practitioners need to understand the legislative and regulatory requirements that apply to psychological practice in the UK. This standard therefore differentiates between working ethically and working legally to reflect the above considerations.

Guidance and signposting

- The Society's *Code of Ethics and Conduct*, *Code of Human Research Ethics*, and supplementary ethical guidelines provide clear ethical principles, values and standards to guide and support psychologists' decisions in the difficult and challenging situations they may face. Further information can be found at **www.bps.org.uk/ethics**.
- The Society's Ethics Committee has produced *Guidance on teaching and assessment of ethical competence in psychology education* (2015), available at **www.bps.org.uk/ethics**, which outlines ethical competencies, and how these may be taught and assessed at different levels of study. Programmes are encouraged to make use of the guidance as appropriate to their provision.

- The Health and Care Professions Council has produced a learning resource that is designed to support the understanding of ethical issues that individuals may encounter. Whilst it is primarily intended to contextualise the HCPC's *Guidance on Conduct and Ethics for Students*, it presents a useful resource for students and trainees at all levels of study (**www.hcpc-uk.org/education/learningresource**).
- All accredited programmes are expected to include formal teaching on ethics, and should be able to demonstrate how working ethically is integral to all aspects of their provision, including research (as outlined below), and placement activities (where applicable). The assessment strategy for the programme should consider understanding of ethical principles as appropriate to the level of study.
- Students need to understand the ethical frameworks that apply to their research, and how to engage with these, as well as understanding the ethical implications of the research that they encounter. They also need to understand ethics as applied to working with people more generally.
- Providers should have in place mechanisms for identifying and dealing with academic and (where applicable) professional misconduct. The programme should consider the ways in which these mechanisms are publicised.

Programme standard 4: Selection and admissions

The programme must apply appropriate selection and entry criteria that are consistent with promoting equality of opportunity and access to psychology to as diverse a range of applicants as possible.

4.1 The programme must implement and monitor equality, diversity and inclusion policies in relation to applicants.

4.2 Programmes should take active steps, including outreach activity, to widen access to entry to the profession of clinical psychology, aiming for diversity within trainee cohorts, and must produce documentary evidence of these strategies. Programmes must periodically review their entry requirements and the ways in which potential to achieve competence is assessed at selection, to ensure that these are consistent with the overall aim of widening access to the profession, and are not discriminatory.

4.3 Selection and entry requirements:

4.3.1 For Doctoral programmes, entry requirements should be established by the education provider in collaboration with stakeholders, as appropriate.

4.3.2 Programmes must provide clear information to trainees indicating that, in order to be eligible for Chartered membership of the Society and full Division membership, they will need to have completed both a programme granting eligibility for the GBC and an accredited Doctoral programme. The reverse is not permissible.

4.4 Recognition of prior learning:

4.4.1 Where the education provider offers applicants the opportunity to seek exemption from undertaking a proportion of the programme, effective processes should be in place for assessing and recognising their prior learning and experience.

4.4.2 Doctoral programmes may operate procedures for the recognition of prior learning (RPL) or existing competence (REC) against the learning outcomes of the accredited award. The RPL procedure should ensure that any exemptions against the taught content of the programme are granted on the basis of learning undertaken at level 7 (level 11 in Scotland).

4.4.3 The REC procedure should ensure that any exemptions against practice requirements are granted on the basis of competence gained following the trainee's achievement of eligibility for the GBC. In addition, any work put forward for REC purposes must have been supervised by an individual who meets the requirements for supervision of professional practice outlined in Programme standard 2.

4.5 For providers that accept trainees on to their postgraduate programmes who do not hold eligibility for the Graduate Basis for Chartered membership of the Society (GBC), a support mechanism should be in place to identify any gaps in such applicants' underpinning knowledge, and ways of addressing these.

4.6 Education providers must demonstrate that the process of selecting candidates for entry on to their programme is based on academic and professional decision-making. Whilst administrative and central services staff play a crucial role in supporting selection and recruitment processes, appropriate academic oversight must be in place. In particular, programme staff should have responsibility for confirming any selection criteria or other checking and validation processes to be applied, and for adjudicating over any non-standard or otherwise complex applications.

4.7 As part of the selection process, both teaching staff and clinical supervisors must be fully involved in the selection of trainees. There must be opportunities for shortlisted applicants to meet existing trainees.

4.8 The Programme Director(s) must ensure that any additional honorary contracts that are required for trainees above and beyond their contracts of employment are in place at the appropriate juncture. This may include, for example, contracts that are required if trainees are undertaking clinical placements or research outside of their employing Trust, but will be dependent upon local circumstances. Trainees who are not NHS employees must hold honorary contracts or a letter of access with the appropriate NHS Provider, issued before they take up their appointments, and with other agencies where applicable.

Rationale for inclusion

The Society is interested in the ways in which education providers implement their equality, diversity and inclusion policies. It is particularly important that those progressing to undertake professional training in psychology, and therefore those moving into employment as psychologists, reflect the demographics of the populations with whom they will be working. Similarly, the Society is keen to promote diversity in psychology trainees progressing towards careers as academics or researchers. Overall, it is important that psychological knowledge and expertise is reflected across a diverse range of people, and that this diversity is ultimately reflected throughout the Society's membership. Widening access to professional training, including by providing greater flexibility in relation to the order of studies that trainees undertake, is key to enhancing the diversity of the workforce in the longer term. The Society is also committed to ensuring that applicants whose first qualification is in a subject other than psychology, and who have gained eligibility for the GBC through completion of a conversion award, are not unfairly disadvantaged by any selection or recruitment policies operated by the education provider (in particular, in relation to their prior academic attainment).

Guidance and signposting

- Chapter B2 of the UK Quality Code addresses Recruitment, Selection and Admission to Higher Education. Chapter B6 also considers Assessment of Students and the Recognition of Prior Learning. Finally, Part C of the Quality Code outlines expectations around the provision of fit for purpose, accessible and trustworthy information regarding the learning opportunities offered for the benefit of a range of audiences, including applicants and the general public. Providers may find it helpful to review their provision against these resources (**www.qaa.ac.uk**).
- The Health and Care Professions Council sets out its requirements around programme admissions, including the recognition of prior learning and equality and diversity, in its Standards of Education and Training (SET 2; **www.hcpc-uk.org/education**).
- The Office for Fair Access (OfFA) is the independent regulator of fair access to higher education in England. Like OfFA, the Society believes that everyone with the potential and ambition to succeed in higher education should have equal opportunity to do so, whatever

their income or background (**www.offa.org.uk**). Whilst its remit covers England only, OfFA provides a series of resources on widening access that all providers will find useful.

- The Society declares its commitment to promote equality, diversity and inclusion and to challenge prejudice and discrimination, and actively promotes a culture of equality, diversity and inclusion within our discipline. In demonstrating achievement of this standard, education providers are encouraged to hold or be in the process of seeking an Athena SWAN award, along with other relevant equality charter marks. Providers of accredited programmes should take steps to identify underrepresented groups (e.g. men, black and minority ethnic students) and encourage their participation in psychology education and training and in the wider psychological workforce. Individuals' identities are shaped by a range of factors that intersect in different ways, and providers should consider the steps they are able to take to promote and improve the participation of other underrepresented groups and to encourage greater representation (**www.ecu.ac.uk**).
- Doctoral programmes comprise a minimum of three years' full-time study (or the part-time equivalent). For some providers, the first year of study comprises study at level 7 (level 11 in Scotland), with the remainder at level 8 (level 12 in Scotland); for others, the entire programme of study is at level 8 (12). Where procedures for the recognition of prior learning (RPL) or existing competence (REC) are in place, these must operate against the learning outcomes of the accredited award, at whatever level these are validated.
- Whilst it is permissible for providers to accept applicants on to their programmes who do not hold the GBC, our experience suggests that such trainees often require additional support to be able to engage fully in teaching and learning building on the different areas of the GBC curriculum, in particular research methods. Some providers have found it useful to ensure that such applicants have undertaken an empirical research project as part of their undergraduate degree, and have completed a research design and analysis module; it may be more appropriate for students who do not meet this criterion to be counselled to complete a conversion programme and to re-apply at a later date.
- Providers wishing to check whether applicants have gained eligibility for the GBC may establish the accreditation status of any qualifications held by applicants by checking their inclusion on the Society's online database of accredited courses (**www.bps.org.uk/accredited-courses**). Applicants whose qualifications are not accredited by the Society may seek confirmation of their eligibility for the GBC by making an individual application to the Society for Graduate membership (**www.bps.org.uk/graduate**).

Programme standard 5: Trainee development and professional membership

The programme must be able to articulate a strategy for supporting trainees' personal and professional development.

5.1 The programme must have in place mechanisms for the support of trainees' personal development, including the provision of discipline-specific careers advice. This should include a personal tutor system that ensures that students have access to advice on their career development.

5.2 Programmes must have a system for monitoring trainees' progress on an annual basis in clinical, academic and research work and in developing professional roles, that is consistent with relevant NHS recruitment and performance management policies and procedures. This monitoring should look at a trainee's work as a whole and lead to guidance on future development, including both specific goals and career guidance. There must be shared documentation for recording this information that demonstrates that each aspect of the trainee's progress, as outlined above, is explicitly and consistently considered.

5.3 Programmes should ensure that trainees monitor and review their own progress and develop skills in self-reflection and critical reflection on practice. Providers must ensure that their graduates explicitly understand how their learning equips them with transferable skills that are of value to employers. Specific consideration should be given to supporting trainees in being able to articulate the skills they are developing as they progress in their studies.

5.4 Programmes must have mechanisms for helping trainees to manage their own personal learning needs and to develop strategies for meeting these. This will include using supervision to reflect on practice, and making appropriate use of feedback received. Systems for trainee support should empower learners to take personal control of their own development, by providing opportunities for the exercise of choice, decision-making, and responsibility within a supportive environment, in order to promote the development of autonomous learning.

5.5 Programmes should ensure that trainees develop strategies to handle the emotional and physical impact of their own practice and to seek appropriate support when necessary, with good awareness of boundary issues. However, trainees should also have the capacity to monitor their own fitness to practice, recognise when this is compromised, and take steps to manage this risk as appropriate.

5.6 Programme Directors, Tutors and Supervisors should be alert to personal issues that bear on a trainee's professional performance and academic achievement, and which often arise from the stresses of taking part in a clinical training programme. Programmes must make provision for such matters to be discussed with trainees routinely, and have in place written procedures on the systems that provide opportunities for such discussions. Trainees must have access to a range of support mechanisms including those available outside the programme team.

5.7 Trainees who experience severe stress, psychological disturbance, or emotional upset should be given assistance in obtaining appropriate help.

5.8 Programmes must have a written policy on health and safety matters and ensure that this is brought to the attention of trainees, and that adequate training is provided. This policy will need to draw attention to the various health and safety policies that will be applicable to trainees; e.g. those of the programme base, the trainees' employer(s) and the organisations within which clinical placements are undertaken.

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

5.10 Towards the end of their training, trainees should be helped to identify their continuing professional development needs. In particular, programmes must ensure that issues relating to the transition from trainee to qualified clinical psychologist are explicitly addressed.

5.11 The programme must provide trainees with information on the benefits of completing an accredited programme, and gaining membership of the Society and its Member Networks at the appropriate level. Providers should emphasise the benefits of Society membership for trainees' and graduates' professional development.

5.12 Trainees should have access to discipline-specific professional development. Psychologists should be involved in supporting student development, and specific resources should be allocated to this aspect of the provision. For postgraduate professional training programmes, this should include the involvement of practitioner psychologist(s) in providing careers advice.

Rationale for inclusion

This standard is included because close attention to trainees' personal and professional development is key to their employability. Education providers may link with local and/or national employers in a variety of ways, and the Society is keen to develop its understanding of these approaches through partnership visits. Additionally, the Society believes it is important that education providers communicate the benefits of completing an accredited programme to their trainees. Belonging to the Society is an integral part of being a psychologist. It recognises graduates' qualifications and reflects their aspiration to represent the highest possible professional standards.

Guidance and signposting

- Chapter B4 of the UK Quality Code addresses Enabling Student Development and Achievement. Chapter B3 also considers Learning and Teaching, and specifically emphasises the need to enable every student to monitor their progress and further their academic development through the provision of regular opportunities to reflect on feedback and engage in dialogue with staff. Finally, Part C of the UK Quality Code addresses the information that should be provided to students about their programme of study and their achievements. Providers may find it helpful to review their provision against these resources (**www.qaa.ac.uk)**.
- The Society's role is to develop and support the discipline of psychology, and to disseminate psychological knowledge to the public and policy makers. Joining the Society enables trainees to contribute to the Society's work and benefit from the resources the Society provides as they develop professionally.

- Completion of an accredited programme offers graduates a clear route to Society membership at the appropriate level, and therefore access to the full range of membership benefits, including a variety of services, publications, conferences, training and networking opportunities. Society membership also presents graduates with opportunities for developing and influencing the profession as leaders in their field in the future. For more information on the benefits of Society membership, see **www.bps.org.uk/membership**.
- In demonstrating their achievement of this standard, education providers should consider the interface between any careers advice and support that might be provided by their central or School/Faculty-based employability unit, and the guidance that can be provided by practitioner psychologists and other qualified practitioners over the course of the programme.
- Postgraduate programmes should also pay particular attention to professional development where trainees on accredited programmes are taught alongside other trainee groups (for example, those that do not hold eligibility for the GBC, or other professional groups).

Programme standard 6: Academic leadership and programme delivery

The education provider must have appropriate human resources in place to support the effective delivery of the programme, including appointing an appropriately qualified and experienced director or co-ordinator.

6.1 Staffing strategy:

6.1.1 Education providers must be able to outline a clear strategy in relation to the leadership and co-ordination of the programme. The Programme Director must operate with a level of autonomy that enables them to effectively oversee the programme's governance and delivery.

6.1.2 Providers need to demonstrate that their overall staffing strategy supports the long-term sustainability of the provision, and the capacity to continue to meet the Society's accreditation standards on an ongoing basis. In the interests of promoting a holistic learning experience for trainees, the Society would normally expect the core programme delivery team to be located predominantly in one department or on one site.

6.1.3 Programmes must have in place sufficient appropriately qualified staff in order to be able to provide a learning experience that meets trainees' needs, and which is underpinned by competent, research-informed teaching. The staff team as a whole needs to be able to deliver (i.e. teach and assess) across the required programme content (see Programme Standard 2) at the appropriate level, and supervise trainees' research.

6.1.4 Education providers must be able to outline the steps they are taking structurally and culturally to advance equality, and to improve the career prospects of underrepresented groups within the discipline and profession.

6.2 Qualifications of Programme Director and staff:

6.2.1 **Programme Directorship:** For postgraduate professional training programmes:

- The Programme Director holds overall professional and academic responsibility for ensuring that the programme meets the Society's standards, and for maintaining the accreditation of the programme.
- The Programme Director must be of an appropriately senior academic status within the education provider, such that the Society may be confident that they can take overall responsibility for, or make a significant contribution to, the programme's day-to-day management and strategic direction.
- The Programme Director must have the programme as his/her major commitment, and be free to devote sufficient time to ensure effective and efficient running.

6.2.2 The Programme Director should be a Chartered psychologist (or eligible for Chartered psychologist status) holding full membership of the Division within whose domain the programme falls and must also be a practitioner psychologist registered with the Health and Care Professions Council (in the domain in which the programme falls). It is expected that the Director will have appropriate professional practice skills and experience.

6.2.3 The Programme Director must normally have appropriate academic, professional practice (for awards leading to eligibility for practitioner status), research and management skills, in addition to prior knowledge and experience of training in the relevant area of applied psychology.

6.2.4 **Programme staff:** For postgraduate professional training programmes:

- All staff contributing to the delivery of accredited programmes will normally hold, as a minimum, a postgraduate qualification in psychology and/or a demonstrable track record in research or other scholarly activity of relevance to applied psychology.
- Dissertation or thesis supervision should only be undertaken by psychologists or other suitably qualified individuals who hold a qualification at Doctoral level, or who hold a demonstrable track record of research in applied psychology.
- A Placement Co-ordinator should be identified who holds responsibility and professional accountability for the oversight (quality assurance) and safeguarding (governance) of any supervised practice undertaken as part of the programme. The Placement Co-ordinator role, and the assessment of students' attainment of professional competencies in practice, may only be undertaken by an HCPC registered practitioner psychologist. Placement organisation also includes a range of operational and logistical tasks that support placement delivery. These may be undertaken by administrative and professional services staff.
- Delivery teams for postgraduate professional training programmes must be able to demonstrate appropriate current links to practice, such that the team as a whole has the necessary knowledge, experience and skills to support trainees' learning, and (where appropriate) development of practice competence. It is expected that the majority of staff on the core delivery team for the programme will be qualified in clinical psychology.

6.3 Staff student ratio:

6.3.1 Education providers should provide a calculation of their current staff student ratio (SSR) in the evidence they submit in support of an application for accreditation, or in advance of a partnership visit. Postgraduate professional training programmes must operate a minimum staff student ratio of 1:10, based on FTEs.

6.3.2 Given minimum staffing requirements, and the range of tasks that programme staff must undertake in order to deliver a quality trainee experience (see 6.4 below), programmes with small cohort sizes will require an enhanced SSR.

6.4 Staffing levels:

6.4.1 There are key roles and functions that the Society considers are essential to the effective and efficient delivery of an accredited programme. Programmes must therefore have sufficient staff with enough time allocated to carry out the range of tasks that are associated with: Teaching; organising, co-ordinating and monitoring placements (if appropriate); training and supporting supervisors or other assessors; research supervision; marking; providing personal support to trainees; supporting their professional development; and liaising with employers, visiting speakers and other external stakeholders.

6.4.2 In the interests of providing a positive and coherent student experience, education providers must ensure that programme staff are readily accessible to students, and that students have clear guidance on arrangements for liaising with staff outside of any core contact hours.

6.4.3 All programmes must pay particular attention to ensuring that staffing levels are such that trainees receive research supervision at a level consistent with the programme's aims and that research supervision loads for staff are appropriate to enable them to provide adequate supervision at the required level.

6.4.4 Where staff have other duties (e.g. other teaching or practice commitments) these must be taken into account in setting staffing levels and must be such that they do not interfere with the execution of the major responsibility of programme delivery. They must also be reflected appropriately in any SSR return.

6.5. Professional services support staff:

6.5.1 Programmes must have access to sufficient dedicated administrative, technical or other learning support staff to support their effective delivery. Postgraduate programmes require specialist administrative support to meet the specific needs of their staff and trainees. This should include awareness of and expertise in overseeing placement/supervised practice activities (where applicable), including an understanding of the fitness to practise procedures that apply.

6.5.2 The education provider must be able to demonstrate that the support that is provided is sufficient to meet the needs of the provision in question. Where shared or distributed arrangements for support staff are in place, the education provider must demonstrate their equivalence to the minimum standards outlined above.

6.6 Staff professional development:

6.6.1 Staff are entitled to expect an institutional culture which values and rewards professionalism and scholarship, and which provides access to development opportunities which assist them in their support for trainee learning. Institutions should support initial and continuing professional development for all staff.

6.6.2 All core members of programme teams are expected to undertake continuing professional development that is necessary to their role within the programme, and, where appropriate, relevant to their professional practice. It is expected that this would include undertaking relevant research, knowledge transfer and other scholarly activity, and/or attendance at relevant conferences. Opportunities for development should be available to all staff who are engaged in, or are supporting, teaching, research and scholarship.

6.6.3 Education providers must have a training and mentoring strategy in place to support early-career staff to undertake core roles, including teaching, supervision and assessment of students' work.

6.6.4 Accredited postgraduate programmes should be conducted within a demonstrable research culture, evidenced by the active current publication record of members of the programme team and other staff allied to the delivery of the programme.

6.6.5 The Programme Director of an accredited postgraduate programme must have sufficient time to conduct research, knowledge transfer, consultancy / organisational and/or clinical work; normally this will be at least one day per week.

Rationale for inclusion

This standard is included as contact with and support from sufficient numbers of appropriately qualified and experienced staff whose professional development is well supported will contribute significantly to the quality of the overall trainee experience. Additionally, the leadership and co-ordination of the programme is central to shaping trainees' experience and their development as psychologists or members of the wider psychological workforce.

Guidance and signposting

- The Society's minimum requirement is that directors of accredited postgraduate programmes are registered with the HCPC as a practitioner psychologist. Whilst it will typically be the case that the Programme Director's qualifications and experience will be specific to the modality in question, colleagues with a broader portfolio of qualifications and experience may also hold directorship roles, provided that delivery of the overall student experience is underpinned by an adequate overall modality-specific resource.
- The Society would encourage Programme Directors to hold Chartered membership and full membership of the relevant Division as a way of demonstrating appropriate qualifications and experience for the role. Information on the requirements for becoming a Chartered Member of the Society can be found at **www.bps.org.uk/chartered-membership** and information about becoming a full member of the division can be found at **www.bps.org.uk/divisional-membership**.
- The Society had produced *Supplementary guidance on staffing for Society-accredited psychology programmes*, available at **www.bps.org.uk/accreditationdownloads**. This provides information to help you meet the Society's staffing standards and calculate your staff student ratio.
- Where appropriate, Programme Directors may be supported in aspects of their role by colleagues with complementary skills and experience to their own. Education providers may wish to consider the roles that other programme team members may take in relation to the leadership and co-ordination of the programme as part of their staff development strategy, particularly in connection with longer-term succession planning or to support the development of leadership potential.
- In the interests of the longer-term sustainable delivery of the programme, providers should have contingency plans in place to ensure that an appropriately qualified and experienced individual has been identified who could deputise for the Programme Director should the need arise (e.g. sickness absence, parental leave, sabbatical).
- The Society expects accredited programmes to be delivered by staff who engage in a range of research activities. A track record of academic and/or practitioner research may be demonstrated in a variety of ways, including successful completion of projects supervised.
- Both the co-ordination and operational components of placement delivery need to be undertaken effectively in order to provide trainees with a supervised practice experience that meets their needs, appropriate to their level of training. The professional oversight and safeguarding aspect of placement co-ordination should be undertaken by an individual who has a good understanding of the professional boundaries within which a trainee should be operating, and how their supervised practice should contribute to their development within the given modality, at the appropriate level. Systems need to be in

place to support consultation across the programme team to ensure that any placements or supervised practice opportunities being identified, selected and undertaken have an appropriate modality-specific focus, and are appropriate to the skills the trainee needs to develop. Any liaison undertaken with placement providers will need to be informed by an understanding of those skills, and of the requirements of the specific programme of training concerned.

- The standards for postgraduate programmes specify certain roles that may only be undertaken by practitioner psychologists. With this in mind, and given the requirement that providers demonstrate that their overall staffing strategy supports the long-term sustainability of the provision, and the capacity to continue to meet the Society's accreditation standards on an ongoing basis, providers should ensure appropriate security across the staff team as a whole. This will ensure that there is some flexibility for the redeployment of resources in the event of staff turnover, and also ensures that responsibility for programme and module development does not sit with a single individual.
- The Society supports the inclusive principles set out in the Equality Challenge Unit's Athena SWAN charter, and would encourage providers of accredited programmes to pursue gaining Athena SWAN recognition and to take steps to improve the career prospects of women psychologists. At undergraduate and postgraduate levels, psychology is a subject that attracts a high proportion of women trainees, and yet the gender balance among senior academics and practitioners reflects a very different picture. Individuals' identities are shaped by a range of factors that intersect in different ways, and providers should consider the steps they are able to take to promote and improve the career prospects of other underrepresented groups and to encourage greater representation. (**www.ecu.ac.uk**).
- Programme providers are encouraged to consult the Society's *Supplementary guidance on the roles and contributions of psychology technical staff* (2014), and its *Supplementary guidance on the roles and contributions of administrative and professional services staff* (2017). (**www.bps.org.uk/accreditationdownloads**).
- Chapter B3 of the UK Quality Code addresses Learning and Teaching, and specifically emphasises the need for higher education providers to assure themselves that everyone involved in teaching or supporting student learning is appropriately qualified, supported and developed. This includes: appropriate and current practitioner knowledge and an understanding of the subject they teach and of the disciplinary scholarship appropriate to the academic level of the students they are teaching; and the necessary skills and experience to facilitate learning in the students they are interacting with, and to use approaches grounded in sound learning and teaching scholarship and practice. Providers may find it helpful to review their provision against these resources (Chapter B3 Indicator 4, **www.qaa.ac.uk**).
- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership, including staffing, in its Standards of Education and Training (SET 3; **www.hcpc-uk.org/education**).

Programme standard 7: Discipline-specific resources

The education provider must have appropriate discipline-specific resources in place to support the effective delivery of the programme.

7.1 The education provider must be able to outline the discipline-specific and general resources and facilities that are in place to support trainee learning. Education providers must offer trainees access to learning resources that are appropriate to the range of theoretical and practical work in which trainees are engaged.

7.2 Education providers should ensure that trainees are advised of the discipline-specific and general learning resources to which they have access, and are provided with the necessary support and/or training to enable them to make appropriate use of these.

7.3 When trainees are on clinical placements they must have access to (at least) a shared office and telephone. There must be adequate arrangements for secretarial and IT support for their placement work, and trainees must be given guidance on the facilities available.

Rationale for inclusion

This standard is included because the learning experience must be underpinned by access to resources that are appropriate to the psychology programme(s) offered by the education provider. The availability of appropriate resources is key to the delivery of psychology as a science, with associated levels of practical work culminating in trainees' completion of individual research at the appropriate level.

Guidance and signposting

- Resources will normally include teaching, tutorial and laboratory space, learning resources (such as texts and journals, available in hard copy and/or electronically, computing facilities), psychological testing materials, specialist equipment supporting psychological research, software supporting data collection and analysis in psychology research, and other IT and/or audiovisual facilities (e.g. to enable the recording of practice role plays and competency assessment tasks), as appropriate to the provision in question.
- Chapter B3 of the UK Quality Code addresses Learning and Teaching, and specifically sets out the expectation that education providers, working with their staff, students and other stakeholders, articulate and systematically review and enhance the provision of learning opportunities and teaching practices, so that every student is enabled to develop as an independent student, study their chosen subject(s) in depth and enhance their capacity for analytical, critical and creative thinking. In particular, there is an expectation that providers maintain physical, virtual and social learning environments that are safe, accessible and reliable for every student, promoting dignity, courtesy and respect in their use (Chapter B3 Indicator 6, **www.qaa.ac.uk**).
- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership, including the resources available to support learning in all settings, in its Standards of Education and Training (SET 3; **www.hcpc-uk.org/education**).

Programme standard 8: Quality management and governance

The education provider's quality management systems must make regular provision for the periodic review of the validity and relevance of the programme, such that it continues to reflect our standards, and meets the needs of the programme's stakeholders.

8.1 Assurance and enhancement of quality:

8.1.1 The quality management mechanisms that are in place should provide for periodic review of the programme's aims and intended learning outcomes and content, the strategies associated with programme delivery, and the assessment methods that are used to evaluate trainees' achievement of the learning outcomes. Overall, they should ensure that the programme continues to reflect contemporary learning, research and practice in psychology.

8.1.2 In order for the Society to be able to accredit a Doctoral programme, the programme must gain and successfully maintain ongoing approval from the Health and Care Professions Council.

8.1.3 Programmes will appoint appropriate External Examiners whose expertise will be of relevance to the breadth and depth of provision being offered. They will ensure that External Examiners are provided with adequate information to support their role, and that systems are in place to monitor action that is taken in response to any issues raised.

8.1.4 The External Examiner for the programme should be a Chartered psychologist (or eligible for Chartered psychologist status) holding full membership of the Division within whose domain the programme falls and must also be a practitioner psychologist registered with the Health and Care Professions Council (in the domain in which the programme falls). Other examiners with a broader range of qualifications and experience may be recruited in addition to undertake specific tasks (e.g. individual thesis examination).

8.1.5 Policies and procedures for the nomination and appointment of External Examiners must be explicit, and, where the programme makes use of additional individuals who are not qualified in the relevant modality (for example, for the individual external examination of trainees' research theses) clear and transparent criteria for their appointment must be in place.

8.2 Stakeholder engagement:

8.2.1 Trainees should have the opportunity to provide feedback on the design and delivery of the programme via the quality management mechanisms that are in place. Programmes should identify ways in which any difficulties identified (whether as informal or formal complaints) may be satisfactorily resolved, and changes to current systems and practices made where appropriate.

8.2.2 Both formal and informal mechanisms of quality assurance should be in place, including regular staff trainee liaison meetings. Issues raised by stakeholders, including trainees, should be documented and contribute to the quality management processes of the provider.

8.2.3 Providers of accredited Doctoral programmes must be able to demonstrate the involvement of appropriate stakeholders in the programme, particularly for the purposes of internal review and governance. This would normally include trainees, practice placement providers, supervisors, and employers; if appropriate, service users and carers must also be involved.

8.2.4 There must be a clear channel of accountability for the work of the Director(s), acceptable to both the academic institution and psychologists within local health and social care providers. A programme based in a university must be regarded as a collaborative enterprise with the NHS, other healthcare providers, the services associated with the programme and other relevant stakeholders.

8.2.5 The programme must have a Programme Board/Training Committee on which the Director(s), teaching staff, clinical supervisors, relevant DCP subsystems, heads of services, trainees, purchasers of training and service users are represented in a way that reflects the joint enterprise upon which the programme is based. The Programme Board/Committee must have a written constitution and terms of reference. It must ensure that the interests of the different stakeholder groups are respected; it must be involved with the overall policy of the programme and the long-term objectives, and should oversee the work of the programme team and any sub-committee structure. It must be acceptable to the different groups involved in the programme and have wide support.

8.2.6 Programmes must work collaboratively with service users, carers and community representatives to identify and implement strategies for the active participation of these stakeholders in the programme. These strategies, and the practical support available to implement them, must be acceptable to the different groups involved in the programme and have wide support.

8.3 Programme management and organisation:

8.3.1 Programmes will normally be associated with a particular geographical area and it is expected that the major part of the funding, teaching and placement resources required by the programme will be provided from that area. Development of any new programme or a major change in any existing programme (which could affect other existing programmes) must be made in consultation with other programmes and local psychologists within the area to avoid impairing the viability of existing programmes. Such consultation must be undertaken from the earliest stage of programme development.

8.3.2 Funding arrangements must be clear and transparent. Programmes must have sufficient ‘core’ funding, such that there is normally an agreed minimum number of funded places in order to ensure stability and predictability in planning the programme. The budget must include funding adequate for agreed expenditure. The budget should be held by the Programme Director(s), or if there are other arrangements they must be clear and acceptable to the Programme Director(s), Programme Board/Committee and purchasers. The programme must have a financial plan detailing the funding available and how resources are/will be allocated. When a programme is expanding it is essential that the necessary additional resources required are identified and agreed with the purchasers before new trainees are accepted on to the programme. Similarly, any contraction of a programme must be managed in a clear and transparent way.

8.3.3 Each programme must be able to identify its own limitations and to indicate how it hopes to rectify these. This might include any limitations in providing learning and placement experiences with particular client groups or in particular clinical or service settings, and should indicate the likely impact of this for prospective trainees, commissioners and employers.

Rationale for inclusion

This standard is included because Accreditation through Partnership relies upon education providers having in place robust quality management mechanisms that facilitate self-evaluation of module and programme learning outcomes against the Society's accreditation standards and other indicators of academic standards. The Society recognises education providers' quality management mechanisms as a reliable source of evidence of continued achievement of the standards.

Guidance and signposting

- Part A of the UK Quality Code addresses Setting and Maintaining Academic Standards. Part C addresses the information that providers set out in relation to their arrangements for managing academic standards and quality assurance and enhancement, and the records they maintain of all arrangements for delivering higher education with others. Providers may also find it helpful to refer to a further five chapters from Part B of the Quality Code (**www.qaa.ac.uk**):
    - Chapter B5: Student Engagement, and in particular the role of students as partners in the assurance and enhancement of their educational experience.
    - Chapter B7: External Examining
    - Chapter B8: Programme Monitoring and Review
    - Chapter B9: Academic Appeals and Student Complaints, and in particular ensuring that students have opportunities to raise matters of concern without risk of disadvantage
    - Chapter B10: Managing Higher Education Provision with Others, which specifically highlights that degree-awarding bodies have ultimate responsibility for academic standards and the quality of learning opportunities irrespective of where these are delivered or who provides them.
- External peer review offers a valuable perspective upon the ways in which the programme compares to others of a similar nature nationally. With this in mind, enabling the Society to have sight of internal quality review reports and External Examiners' reports, and the programme's response to these, allows our reviewers to gain insight into the extent to which the education provider's quality management mechanisms function effectively for the benefit of trainees, and the discipline as a whole.
- The Health and Care Professions Council sets out its requirements around programme governance, management and leadership in its Standards of Education and Training (SET 3) together with information about its programme approval and monitoring processes (**www.hcpc-uk.org/education**).
- All providers are encouraged to consider the ways in which employer feedback might be harnessed as part of the quality management and programme development process.

Appendix 1: Example clinical practice portfolio

DOCTORATE IN CLINICAL PSYCHOLOGY

TRAINEE PORTFOLIO OF CLINICAL PRACTICE

Trainee...

Section A: **Log of clinical experiences**
Section B: **Therapy competencies**
Section C: **Psychological testing competencies**
Section D: **Cumulative record**

Section A: Log of clinical experiences

There are two logs:

1. **Clinical assessments and interventions – principal/joint work**
   Complete for all clinical contacts where you are the principal or joint lead.

Date:	Date at which the service user was first seen/contacted.
Initials:	Service user initials or other code.
Gender age:	Client's gender and age (e.g. M42).
Presentation:	Presentation identified or addressed by the trainee, not necessarily identical with those stated at referral (e.g. adjustment difficulties, severe challenging behaviour).
Assessment:	Brief summary of assessment methods (e.g. family interview, school observation, neurodevelopmental assessment, case note analysis).
Intervention:	Brief summary of any interventions undertaken with the client, family, carers, other professionals etc. (e.g. systemic therapy, CBT, consultancy, indirect work with staff etc).
Contact hours:	Number of hours the service user (family, carers etc.) seen in face-to face contact. Each should have only one entry with the number of hours totalled at the end (e.g. 10).
Consultation hours:	Number of hours spent consulting with staff, school etc.

All entries will need to be authenticated by a supervisor's signature.

2. **Log of non-therapy experiences**

This section should be used to list other types of clinical activity such as teaching, training, presentations, research activity, inter-professional liaison, multidisciplinary work, supervision, consultancy, service user organisation contacts, leadership experiences etc.

1. Log of clinical contacts – Trainee as Principal or Joint Therapist

Placement number and definition:..

Date	Initials	Gender & age	Presentation	Assessement	Intervention	Client contact hours	Consult hours

Supervisor signature:..

Trainee signature:..

(please add further pages as required)

2. Log of non-therapy experiences

Placement number and definition:...

Key experiences	Brief summary of nature of experience undertaken in this placement
Teaching/training/ supervision	
Consultancy/ indirect work	
Multidisciplinary/ inter-professional work	

Key experiences	Brief summary of nature of experience undertaken in this placement
Inter-agency liaison and influence	
Organisational initiatives and interventions	

Supervisor signature:...

Trainee signature:...

(please add further pages as required)

Section B: Therapy competencies

This section is proposed as one way of tracking the accumulation of model-specific skills across placements. These are examples only and are not meant to be prescriptive. Courses have freedom to choose which approach they teach in addition to CBT: Some may have one additional model, others may have more than one. However each needs to be subject to a systematic means of tracking the level of competence acquired by the trainee.

Cases where therapy competencies have been demonstrated within placements should be shaded in the following tables and certified by the placement supervisor. **Not every skill needs to be covered on all placements!**

A cumulative portfolio of CBT competencies should be kept across placements.

1. Cognitive Behaviour Therapy

*This competence model has been adapted from the CORE CBT competence framework for depression and anxiety disorders (**www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm**). It is intended to offer a means of tracking the development of the range of competencies identified as important in showing evidence of working within a cognitive-behavioural framework.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

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

Applied CBT to specific problems:																				
Phobia/Social Phobia/GAD/Panic																				
OCD																				
PTSD																				

Depression																				
Psychosis																				
Health related presentations																				
Family functioning																				
Adjustment and coping																				
Addictive behaviours																				
Eating disorders																				
OTHER (please specify)																				
OTHER (please specify)																				

Demonstrated generic CBT skills:																				
Socialisation and rationale of CBT treatment																				
Identified cognitive distortions and biases																				
Agreed and collaboratively set agenda for session content and structure																				
Developed collaborative hypotheses																				
Developed intervention plans																				
Planned and reviewed ‘homework’																				

Used measures and self-monitoring to guide and evaluate therapy																				
Demonstrated knowledge of safety behaviours and maintenance cycle and used to inform goals/targets																				
Used problem solving																				
Ended therapy appropriately and planned for the longer-term																				
Selected and applied most appropriate CT and BT method																				
Managed obstacles during therapy																				

Specific Behavioural and Cognitive Therapy skills:																				
Used exposure techniques																				
Used Applied relaxation and/or applied tension																				
Used activity monitoring and scheduling																				
Implemented a contingency programme																				
Elicited key cognitions/images																				
Used thought records																				

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

Supervisor signature:...

Trainee signature:..

Date:...............................

2. Psychodynamic Therapy

*This competence model has been adapted from the CORE psychodynamic competence framework (***www.ucl.ac.uk/clinical-psychology/CORE/psychodynamic_framework.htm***). It is intended to offer a means of tracking the development of the range of competencies identified as important in showing evidence of working within a psychodynamic framework.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied psychodynamic therapy in context of:																				
Adult																				
Older Adult																				
Child/Family																				
Intellectual Disability																				
Other (specify)																				
Other (specify)																				

Applied psychodynamic therapy to specific problems:																				
Anxiety presentations																				
Depression																				
Relationship difficulties																				
Personality presentations																				
Presentations of childhood																				
Health related presentations																				
Addictive behaviours																				
Eating disorders																				
OTHER (please specify)																				
OTHER (please specify)																				

Experience in core psychodynamic competencies of:																				
Assessed for suitability for dynamic psychotherapy																				
Engaged client in psychodynamic approach																				
Derived an analytic/psychodynamic formulation																				

Recognised and worked with unconscious communication																				
Explored the unconscious dynamics influencing relationships																				
Helped the client become aware of unexpressed or unconscious feelings																				
Managed boundaries within the therapeutic relationship																				
Used therapeutic relationship as a mechanism of change																				
Showed ability to work through the termination phase of therapy																				
Able to adapt methods to work with children																				
OTHER (please specify)																				

Specific analytic/dynamic techniques:																				
Ability to make dynamic interpretations																				
Made use of and worked with transference																				
Made use of and worked with counter-transference																				
Recognised and worked with defences																				

Recognised and made use of projection and projective identification																				
OTHER (please specify)																				

Supervisor signature:..

Trainee signature:...

Date:.............................

3. Systemic Therapies

*This competence model has been adapted from the CORE competence framework for systemic psychological therapies (***www.ucl.ac.uk/clinical-psychology/CORE/systemic_framework.htm***). It is intended to offer a means of tracking the development of the range of competencies identified as relevant to systemic approaches. A small 's' is used in tracking basic competencies, which can be used and applied in many areas where 'the system' is taken into account in assessing, developing understandings and interventions which may include a multi-layered definition of who 'the client' is. A big 'S' is used in tracking the specific skills drawn from systemic approaches. Use of a big 'S' implies further study and implementation of specific models of working, as in e.g. Family Therapy.*

Programmes may adopt alternative means of tracking therapy competencies using appropriately benchmarked methods, but should be able to articulate for the benefit of trainees, supervisors, and external audiences the choice of framework used.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied systemic therapy in context of:																				
Adult																				
Older Adult																				
Child/Family																				
Intellectual Disability																				
Other (specify)																				
Other (specify)																				

Applied systemic therapy to specific problems:																				
Anxiety presentations																				
Depression																				
Relationship difficulties																				
Presentations of childhood																				
Developmental transitions																				
Family functioning																				
Health related presentations																				
Addictive behaviours																				
Eating disorders																				
OTHER (please specify)																				
OTHER (please specify)																				

Demonstrated basic systemic competencies of:																				
Demonstrated knowledge of systemic influences drawn from psychological and social theories (e.g. group processes, decision making in groups, minority influence, crowd culture)																				
Conducted systemic assessment:																				
Understood problem from a systemic perspective																				
Gathered information from multiple perspectives																				
Explained rationale and engaged client(s) in a developmentally appropriate way																				
Developed and shared with client(s) systemic hypotheses and/or a systematic formulation																				
Provided interventions from a systemic perspective:																				
Helped client(s) identify and change problematic patterns																				
Promoted change through tasks between sessions																				

Monitored and reviewed progress in therapy																				
Managed endings appropriately																				
OTHER (please specify)																				
OTHER (please specify)																				

Specific Systemic competencies:																				
Demonstrated knowledge of Systemic principles and theories (e.g., circularity; multiple perspectives; repetitive patterns of interaction; trans-generational patterns)																				
Employed circular interviewing/questioning																				
Used reframing techniques to enable client(s) to understand the development and maintenance of the problem																				
Enabled client(s) to identify individual and family strengths																				
Used mapping techniques to identify current, historical and trans-generational patterns (e.g., ecomaps; lifelines; family circles)																				

Demonstrated ability to work with systemic team (e.g., reflecting team; reflection on process in supervision)																				
Demonstrated self-reflexive practice/ personal awareness (e.g., in supervision)																				
Demonstrated awareness of cultural diversity (e.g., in supervision; with reflecting team)																				
OTHER (please specify)																				
OTHER (please specify)																				

Supervisor signature:...

Trainee signature:..

Date:.............................

Section C: Psychological Testing Competencies

All performance and paper and pencil psychometric assessments should be logged in the following table. Tests should only be logged where the trainee has utilised the test as principal/joint lead in a case (not observation only). Supervisors should validate where test use is assured.

A cumulative log should be kept across placements.

Placement number and definition:...

1. Self-report/informant measures

Clinical use/Reason for assessment? (e.g. outcome measure, treatment planning etc.)	**Age**	**Tests used**	**Administration** *(check)*	**Appropriate interpretation (check)**	**Supervisor signature**

2. Performance based psychometrics

Clinical use/Reason for assessment? (e.g. outcome measure, treatment planning etc.)	Age	Tests used	Administration *(check)*	Appropriate interpretation (check)	Supervisor signature

Section D: Cumulative training record

The cumulative training records summarise clinical activity as benchmarked across the accreditation criteria for clinical presentations, service settings, age range, modes of work etc. The cumulative record should be used to plan further training requirements in the light of cumulative experiences to date. They also ensure that, by the end of training, a satisfactory range of experience will have been attained on which competencies have been evidenced. One record should be completed during each placement and the cumulative record updated at the end of each placement.

Recording should be done by shading a box for each domain a given case relates to. Each 'case' will undoubtedly have relevance to multiple domains. This process should be completed through discussion with your supervisor at case closure. The record should be signed by you and your supervisor at the end of placement and will be used to plan further placement experiences at appraisal. Records should be consistent with the information recorded in the log of clinical activities (section A).

The cumulative record should be updated at the end of each placement and be used in appraisal to plan future training experiences. This will also be utilised as evidence to inform the final training transcript.

Placement number and definition:..

		1	2	3	4	5	6	7	8	9	10	11	12+
Breadth and diversity of presentation	Acute												
	Enduring												
	Mild												
	Severe												
	Organic												
	Psychosocial												
	Coping/adaptation												
	Problem amelioration												
	Challenging behaviour												
	Communication difficulties												
Developmental period/age range	Infancy/Pre-school												
	Child												
	Adolescent												
	Adult												
	Older Adult												

Intellectual functioning	Average												
	Mild/specific cognitive deficits												
	Moderate/severe cognitive deficits												
Service delivery systems	Inpatient												
	Residential/Supported												
	Secondary												
	Primary care												
	Other												
Levels of intervention	Individual												
	Family												
	Couple												
	Group												
	Organisational												
	Via carer												
Modes of work	Direct												
	Indirect – staff/carers/ schools												

	Multi-disciplinary												
	Other												
Psychological model/ framework	Cognitive Behaviour												
	Psychodynamic												
	Systemic												
	Humanistic												
	Other (define)												
Psychometrics	WAIS-IV												
	WISC-IV												
	WMS-IV												
	CMS												
	HADS												
	SDQ												
	IES-R												
	Other (list)												

Supervisor signature:...

Trainee signature:...

Date:..............................

Cumulative Summary Record

		1	2	3	4	5	6	7	8	9	10	11	12+
Breadth and diversity of presentation	Acute												
	Enduring												
	Mild												
	Severe												
	Organic												
	Psychosocial												
	Coping/adaptation												
	Problem amelioration												
	Challenging behaviour												
	Communication difficulties												
Developmental period/ age range	Infancy/Pre-school												
	Child												
	Adolescent												
	Adult												
	Older Adult												

Intellectual functioning	Average												
	Mild/specific cognitive deficits												
	Moderate/severe cognitive deficits												
Service delivery systems	Inpatient												
	Residential/Supported												
	Secondary												
	Primary care												
	Other												
Service delivery systems	Individual												
	Family												
	Couple												
	Group												
	Organisational												
	Via carer												
Service delivery systems	Direct												
	Indirect – staff/carers/ schools												

	Multi-disciplinary												
	Other												
Psychological model/ framework	Cognitive Behaviour												
	Psychodynamic												
	Systemic												
	Humanistic												
	Other (define)												
Psychometrics	WAIS-IV												
	WISC-IV												
	WMS-IV												
	CMS												
	HADS												
	SDQ												
	IES-R												
	Other (list)												

Supervisor signature:...

Trainee signature:...

Date:...............................

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www.bps.org.uk/partnership

The British
Psychological Society
Partnership & Accreditation

The British
Psychological Society

Code of Ethics and Conduct

February 2018

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Tel: 0116 254 9568; e-mail mail@bps.org.uk.

1 Introduction

1.1 The British Psychological Society sets and upholds high standards of professionalism, and promotes ethical behaviour, attitudes and judgements on the part of Psychologists. Under the terms of its Royal Charter, the Society maintains a Code of Ethics and Conduct; which has been regularly updated prior to this current revision, most recently in 2009 (archived version available on the website).

1.2 In formulating this Code, existing Codes, Society guidance and changes in societal expectations of professionals were considered. This Code is the over-arching guidance document for all members of the Society; specific additional guidance is provided in the *Code of Human Research Ethics* and *Practice Guidelines.* Additional support can be found on the Society's website: **www.bps.org.uk**.

1.3 The Code contains the professional standards that members of the Society should uphold. The aim of the Code is to provide a framework for guiding the decision-making for all psychologists. The framework allows sufficient flexibility for a variety of approaches, contexts and methods and reflects the ethical standards that apply to all. Psychologists need to familiarise themselves with any legal frameworks, regulatory requirements and other guidance relevant to the particular context in which they work including any specific guidance in the *Code of Human Research Ethics* and *Practice Guidelines.*

1.4 We live in a rapidly changing world, where new ethical challenges come from many sources. These include the unprecedented opportunities provided by innovations in science and technology as well as the threats posed by climate change and global conflicts. Supplementary guidance on these new challenges is often published by the Society and can be found at: **www.bps.org.uk**.

1.5 Psychologists may need to make decisions in difficult, changing and unclear situations. The Society expects that the Code will be used to form a basis for consideration of ethical questions, with the Principles in this Code being taken into account in the process of making decisions, together with the needs of persons, peoples and organisations in the specific circumstances in which the decision is to be made. No code can replace the need for Psychologists to use their own professional and ethical judgement.

1.6 Principles and the Codes that spell out their application serve primarily as guidelines for thinking about the decisions individuals need to make. The discipline of Psychology, both as a science and a profession, exists within the context of human society. Accordingly, a shared collective duty for the welfare of human and non-human beings, both within the societies in which Psychologists live and work, and beyond them, is acknowledged.

1.7 It is important for Psychologists to be aware of research that has relevance to ethics.

1.8 Behaving ethically requires ethical awareness – noticing what ethical issues are raised by a course of action makes it more likely that ethical practice will follow.

1.9 Ethical reasoning is often subject to various competing biases. Maintaining awareness of such biases is important when trying to think through ethical challenges. These considerations currently include but are not limited to, salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (acting to maintain consistent beliefs). This list will evolve over time with the advancement of knowledge in this area. Psychologists are therefore well placed and encouraged to consider these factors in their own decision-making.

1.10 Acting ethically can be affected by a number of individual and group influences as well as context, so even though an individual may be aware of ethical issues and has worked through the decision-making process, their motivation or ability to act ethically may be compromised. Key considerations include conformity and resistance, context, power, emotion, and the role of social norms, organisational pressures and group/self-identity. Psychologists are well placed to consider and reflect on these factors in their own decision-making.

1.11 Psychologists should consider it good practice to record their decision processes when confronted with a particularly challenging ethical issue so that it is available for future reference if that decision is re-visited.

1.12 Acting ethically depends on many skills including a capacity for leadership, effective prioritisation and risk management. Decisions may have to be made about which of many competing ethically relevant actions should come first, or between courses of action where none are entirely optimal. Fear, difficulty, fatigue and perverse reward systems are some of the many environmental issues that could influence implementation of a decision.

1.13 As Psychologists, we are aware of the importance of both context and character affecting our behaviour. Being aware of how to develop character strength has a long tradition. This Code therefore encourages all Psychologists to be mindful of their strengths and weaknesses in order that they are able to behave in the most ethical way possible.

2. Structure of the Code

2.1 This Code is based on four ethical Principles, which constitute the main domains of responsibility, within which ethical issues are considered. These have been agreed after many years of consultation within and outside the profession. The manner in which they apply and the contexts that they apply in will inevitably change over time.

They are:

(i) Respect;

(ii) Competence;

(iii) Responsibility;

(iv) Integrity.

2.2 Each Principle is described in a statement of values, reflecting the fundamental beliefs that guide ethical reasoning, decision-making and behaviour. Under each principle we list issues and considerations that Psychologists should be aware of in applying the Principles in their work. Broad 'headline' categories are included and a list additional resources that expand on the application of these values in the Psychologist's field of work are provided at the end of this document.

3. Ethical principles

3.1 Respect

Respect for the dignity of persons and peoples is one of the most fundamental and universal ethical principles across geographical and cultural boundaries, and across professional disciplines. It provides the philosophical foundation for many of the other ethical Principles. Respect for dignity recognises the inherent worth of all human beings, regardless of perceived or real differences in social status, ethnic origin, gender, capacities, or any other such group-based characteristics. This inherent worth means that all human beings are worthy of equal moral consideration.

Statement of values: Psychologists value the dignity and worth of all persons, with sensitivity to the dynamics of perceived authority or influence over persons and peoples and with particular regard to people's rights.

In applying these values, Psychologists should consider:

(i) Privacy and confidentiality;

(ii) Respect;

(iii) Communities and shared values within them;

(iv) Impacts on the broader environment – living or otherwise;

(v) Issues of power;

(vi) Consent;

(vii) Self-determination;

(viii) The importance of compassionate care, including empathy, sympathy, generosity, openness, distress, tolerance, commitment and courage.

3.2 Competence

Psychologists, whether academic, practitioner or in training, may offer a range of services that usually require specialist knowledge, training, skill and experience. Competence refers to their ability to provide those specific services to a requisite professional standard. A psychologist should not provide professional services that are outside their areas of knowledge, skill, training and experience.

Statement of values: Psychologists value the continuing development and maintenance of high standards of competence in their professional work and the importance of working within the recognised limits of their knowledge, skill, training, education and experience.

In applying these values, Psychologists should consider:

(i) Possession or otherwise of appropriate skills and care needed to serve persons and peoples;

(ii) The limits of their competence and the potential need to refer on to another professional;

(iii) Advances in the evidence base;

(iv) The need to maintain technical and practical skills;

(v) Matters of professional ethics and decision-making;

(vi) Any limitations to their competence to practise taking mitigating actions as necessary;

(vii) Caution in making knowledge claims.

3.3 Responsibility

Because of their acknowledged expertise, Psychologists enjoy professional autonomy; responsibility is an essential element of autonomy. Psychologists must accept appropriate responsibility for what is within their power, control or management. Awareness of responsibility ensures that the trust of others is not abused, the power of influence is properly managed and that duty towards others is always paramount.

Statement of values: Psychologists value their responsibilities to persons and peoples, to the general public, and to the profession and science of Psychology, including the avoidance of harm and the prevention of misuse or abuse of their contribution to society.

In applying these values, psychologists should consider:

(i) Professional accountability;

(ii) Responsible use of their knowledge and skills;

(iii) Respect for the welfare of human, non-humans and the living world;

(iv) Potentially competing duties.

3.4 Integrity

Acting with integrity includes being honest, truthful, accurate and consistent in one's actions, words, decisions, methods and outcomes. It requires setting self-interest to one side and being objective and open to challenge in one's behaviour in a professional context.

Statement of values: Psychologists value honesty, probity, accuracy, clarity and fairness in their interactions with all persons and peoples, and seek to promote integrity in all facets of their scientific and professional endeavours.

In applying these values, Psychologists should consider:

(i) Honesty, openness and candour;

(ii) Accurate unbiased representation;

(iii) Fairness;

(iv) Avoidance of exploitation and conflicts of interest (including self-interest);

(v) Maintaining personal and professional boundaries;

(vi) Addressing misconduct.

4 Conclusion

4.1 This Code cannot and does not aim to provide the answer to every ethical decision a Psychologist may face. The Code provides the parameters within which professional judgements should be made. However, it is important to remember to reflect and apply a process to resolve ethical challenges.

5 Further information

5.1 If you have a question about the Code or about professional ethics, there are several potential sources of advice. There is a dedicated Ethics area on the Society's website which provides a range of resources, including Frequently Asked Questions. (www.bps.org.uk).

5.2 The Society strongly recommends that all members consider taking out professional indemnity insurance that includes legal cover. Professional indemnity insurance is a legal requirement for members who are registered with the Health & Care Professions Council (HCPC).

5.3 The Society cannot determine allegations for fitness to practise. For further details about making a complaint about a Psychologist – please go to **www.bps.org.uk** or the HCPC website: **www.hcpc-uk.co.uk**.

The Society is only able to consider allegations against Society members acting as members of the Society and not in their professional capacity. These will be dealt with in accordance with the Member Conduct Rules.

Other key documents

British Psychological Society (2014). *Code of Human Research Ethics.* Leicester: Author

British Psychological Society (2015). *Guidance on Teaching and Assessment of Ethical Competence in Psychology*. Leicester: Author.

British Psychological Society (2017). *Practice Guidelines.* Leicester: Author.

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The British
Psychological Society
Promoting excellence in psychology

Division of
Clinical Psychology

e –Professionalism
Guidance on the use of social media by clinical psychologists

Summary – Recommendations

- Social media represent a revolution in communication between individuals and organisations. They present significant opportunities to promote and develop the profession and service user experience. Social media also present some potential challenges with respect to maintenance of appropriate professional boundaries since, by their very nature, they facilitate less restrictive interaction.
- Clinical psychologists should not transmit any service user identifiable information via social media without explicit permission from the service user to publish the material online.
- Clinical psychologists should be aware that standards of personal conduct apply to use of social media and, as such, should always consider the appropriateness of material submitted to social media and are strongly advised to use (and monitor and update regularly) privacy settings to restrict access to social media which contains personal material. This could also apply to family members.
- If clinical psychologists interact with service users via social media they should communicate clearly with regards to the nature of the relationship. Interaction with current or former service users via social media in a personal/social capacity should only be undertaken with caution and after careful consideration of the relevant professional and ethical issues.
- Interactions between colleagues within professional and educational settings can also raise issues and dilemmas particularly where there are power imbalances and an evaluative component. It would be expected that individuals and training courses would ensure that this is addressed transparently and reflectively.
- Whilst conducting research using social media has many advantages and is to be welcomed, there are some practical and ethical issues that can arise, which may require advice from more experienced colleagues.

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

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Introduction

This guidance is designed to help both qualified clinical psychologists and trainees to positively engage with social media whilst also adhering to standards of professional and ethical conduct. The guidance works from a broad stance given the rapid proliferation and wide range of social media, queries raised within the profession, and examples of concerns coming from the HPC and other professional groups.

The aim is to strike a balance between alerting psychologists to the issues within social media in relation to personal/professional boundaries and highlighting the potential benefits of social media to service users, clinicians and researchers.

Psychologists are advised to use this document to provide pointers and guidance to assist them in making decisions about how to incorporate social media within their lives. They are also advised to

- refer to any guidance from their employing authority on this matter;
- gain advice from senior colleagues and, where client confidentiality is an issue, the local Caldicott Advisor;
- consult the Health Professions Council (HPC website);
- consult the BPS/DCP office with specific questions;
- the BPS Ethics Committee has also produced supplentary guidance on the use of social media (BPS, 2012).

For convenience, the guidance has been separated into five broad issues relating to the use of social media.

1. Service user confidentiality.
2. Personal material transmitted via social media.
3. Interaction with service users via social media.
4. Interactions between colleagues within professional and educational settings.
5. Research.

What are social media?

Social media employ mobile and web-based technologies to create highly interactive platforms via which individuals and communities share, co-create, and modify user-generated content (Kietzmann et al., 2011). The term ‘social media’ encompasses not just social networking websites such as Facebook and LinkedIn but also video and photo sharing sites such as YouTube and Flickr, micro-blogging applications such as Twitter and aggregator sites such as Digg and even virtual worlds. It is possible to categorise these in terms of the degree of self-disclosure and other factors (Kaplan & Haenlein, 2010).

The recent explosion of social media presents both new opportunities and challenges for clinical psychologists. Kietzmann et al., (2011) argue that ‘social media introduce substantial and pervasive changes to communication between organisations, communities, and individuals’ (p. 250). These changes create the potential for material to be transmitted to a very wide audience without the express consent or knowledge of the originator with potentially damaging consequences. For instance, an ill-thought comment in the local pub after work may cause offence to one's colleagues; however, a similar comment posted online as a 'tweet' or on a Facebook page has the potential to cause distress to colleagues and service users, and damage to the individual's professional reputation and potentially to the profession itself.

On the other hand, the facility to interact with individuals across the globe who share similar interests and concerns has the potential to deliver huge benefits to service users, facilitate promotion of professional and research activities in addition to enhancing one's social life.

- There is evidence that its user friendly interface and popularity may facilitate the engagement of some 'hard to reach' client groups, such as adolescent men, or provide a means for social presence for people who have limited access or who struggle to manage face-to-face interactions.
- There is a developing area of e-therapy, websites for therapy and self-help, use of chat rooms.
- There may be a deliberate organisational drive to develop this medium as a means to communicate quickly and directly with others, such as the DCP's use of Twitter.

1) Service user confidentiality

By far the least ambiguous area in which to provide guidance is in relation to service user confidentiality in the use of social media. All clinical psychologists will be aware of their duty to protect service users' confidentiality in relation to material arising from clinical work. HPC *Standards of Conduct, Performance and Ethics* (2008) state that 'You must respect the confidentiality of service users' whilst the BPS *Professional Practice Guidelines* (2008) state that 'Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential'. However, there have been a number of cases reported where health professionals have inadvertently breached client confidentiality in their use of social media. A survey of internet blog postings by health professionals, Lagu et al. (2008) found that individual patients were described in nearly half of all blogs and 17 per cent provided potentially patient-identifiable information.

It may seem hard to imagine how such situations could arise. However, in contrast to other media such as publishing a paper in a print journal, the nature of many social media is such that information is transferred between members of a discrete social network so easily and quickly that they can easily be treated in the same way as a chat with a colleague in a workplace or in a private telephone conversation. In other words, assumptions may be made that the interaction is entirely private, restricted to a small number of individuals and no trace of the conversation will remain. However, this is certainly not the case. The privacy setting on Facebook, for instance, might lead individuals to feel secure and both instant and asynchronous messaging (such as e-mail and private messaging on social networking sites) may appear a secure means to discuss confidential information. However, even with use of privacy settings, a record of communications remains that is potentially accessible by an unintended audience. It is important to bear in mind that discussing details of a service user's difficulties or behaviour, even without the explicit mention of their name, may still represent a breach of confidentiality because of the potential of identification.

Thus, social media are potentially publicly-accessible environments, irrespective of privacy settings. It is therefore essential that clinical psychologists do not transmit any service user identifiable information via social media without explicit permission to publish the material online. Failing to observe this guidance is a breach of the HPC standards of conduct and, as such, is grounds for fitness to practice proceedings to be brought. The 2011 HPC annual report on fitness to practise reports has an example of one case (HPC, 2011).

2) Personal material transmitted via social media

A rather more grey area is the appropriateness of material transmitted via social media such as communicating personal opinions via Twitter or posting personal photos on Facebook. One point of view is that, whilst certain standards of professional behaviour are rightly expected within a clinical setting, these do not extend to one's social life in which individuals have a basic right to freedom. Most clinical psychologists would agree that maintaining a clear distinction between work and personal life is positive and that the definition of what constitutes appropriate behaviour differs between the two settings. However, it is important to note that the HPC *Standards of Conduct, Performance and Ethics* (2008) states that 'You must keep high standards of personal conduct, as well as professional conduct' and 'You must justify the trust that other people place in you by acting with honesty and integrity at all times. You must not get involved in any behaviour or activity which is likely to damage the public's confidence in you or your profession.' Furthermore, the BPS *Code of Ethics and Conduct* (2009) state that psychologists should: 'Avoid personal and professional misconduct that might bring the Society or the reputation of the profession into disrepute' (paragraph 3.1 (ii)).

It is therefore clear that there are certain expectations regarding the behaviour of clinical psychologists in their personal lives, including in relation to the use of social media. There is no clear, comprehensive definition of the 'high standards of personal conduct' referred to by the HPC. However, in practice, this is normally taken to mean not behaving in a way that would cast serious doubt about one's fitness to practice – for instance, dependence on illicit substances, engaging in physically violent or sexually abusive behaviour or engaging in abusive, racist or homophobic behaviour. It is important to note that the vast majority of HPC's fitness to practice cases relate to professional conduct within the workplace; of those relating to personal conduct, inappropriate relationships with service users and criminal convictions predominate. Posting photos of oneself in social situations such as at parties on Facebook or engaging with banter with friends, whilst potentially embarrassing if inadvertently shared with professional colleagues or service users, would not constitute grounds for fitness to practice proceedings, although the BMA *Guidelines for Using Social Media* (2011) mention an examples of photos that were posted on Facebook that did constitute grounds for disciplinary action.

However, it is also important to be aware that publishing comments which could be detrimental to one's employing organisation may represent a breach of terms of employment and could lead to disciplinary action. Disclosure of damaging information may be defensible in certain 'whistle-blowing' scenarios, such as uncovering abuse or malpractice, when such a disclosure is in the public interest. However, there are established 'whistle-blowing' procedures which should be followed as opposed to using social media in order that the concerns are investigated most effectively (Department of Health, 2010). Furthermore, if unsubstantiated comments transmitted via social media damage an individual's reputation or the reputation of an organisation, this can amount to defamation, which could potentially result in legal action.

Finally, clinical psychologists and trainees should be aware of reports that employers are increasingly making use of social media as part of recruitment process (Peacock, 2009). Employers can make use of online content and several people have been dismissed for calling in sick when their Facebook profiles have shown them to be engaging in other activities or tired/hung over from the previous night out, whilst others have been disciplined or fired for making sexual comments about colleagues, saying how much time they waste or what they are able to steal from work.

Despite these risks, Thompson et al. (2008) found in a survey of medical students only one-third had used privacy settings on their Facebook accounts.

There are also some risks inherent within the use of social media where maintaining boundaries and ensuring privacy is of particular concern.

1. It is important to appreciate that the action of joining another's network gives them full access to one's own network and vice versa, allowing a view of all personal interactions.
2. Privacy settings can be complex and can change without warning; it is important to revisit these on a regular basis.
3. Where an individual has set up a professional site using one social network and a personal account in another it is still possible that there could be 'leakage' allowing information to flow between sites and to be distributed to 'unintended audiences'.
4. Despite appropriately set privacy settings it is feasible for a 'friend of a friend of a friend' to be able to raise concerns about someone's urgent mental health problems; this could be out of hours and feel invasive of one's private space (obviously this can, and does occur, without social media).
5. Family members also need to be aware of the possibility that clients may browse their online profiles for information about psychologists and potentially make contact, thus psychologists are strongly advised to ensure that their family members, particularly children, use privacy settings to prevent open access.

Clinical psychologists should be aware that standards of personal conduct apply to use of social media and, as such, should always consider the appropriateness of any material submitted via social media and are strongly advised to use (and monitor and update regularly) privacy settings to restrict access to social media which contains personal material. This could also apply to family members.

3) Interaction with service users via social media

The relative ease of interaction provided by social media is, of course, one of their main attractions. There is no doubt that this has a wide range of potential benefits; for instance, a psychologist working within a specialist area may join a social network for other professionals working in that field within the UK or worldwide. This can facilitate dramatically faster development and dissemination of good practice and new research findings than traditional media and is thus undoubtedly in the interests of the profession and service users. Such networks may be exclusive to professionals but other networks, such as those with a focus on a particularly disorder, may be open to service users. It is both unrealistic and undesirable that the sharing of views, experiences and information in this way is restricted only to psychologists or other health professionals.

Social media also offer enormous potential to clinical researchers in terms of recruiting participants for research studies. Thus a researcher may establish a page on Facebook or other networking site to publicise their research findings to the general public and make contact with individuals interested in forthcoming studies.

Social media are increasingly used as a marketing tool by a range of organisations. Clinical psychologists may therefore opt to use social media on an individual basis to promote their own professional activities or contribute to an organisational profile.

It is certainly clear that social media have the potential to blur the boundaries of personal and professional relationships, with potentially negative effects. The British Medical Association has recently issued guidance to doctors advising them not to accept friend requests from current or former patients on Facebook or other social networking sites (BMA, 2011).

The Division of Clinical Psychology believes that an outright prohibition of all interaction with current or former service users is overly simplistic. Instead, it is recommended that if clinical psychologists interact with current or former service users via social media they should communicate clearly with regards to the nature of the relationship, making it explicit that this is in a professional capacity with the clear intent to communicate with service users by, for instance, maintaining separate profiles for their professional interests and their personal social life and making a statement on a networking profile fan page clearly indicating the purpose of their engagement in the particular network (e.g. 'I have established this profile specifically to facilitate my own professional interest in promoting care for clients with dementia. As such I am very happy to interact with professionals, service users and carers via this profile. Please note that this is a personal profile and not part of my role with St Anywhere's NHS Trust. If you have any queries about matters related to my work at the Trust please contact them directly.').

Interaction with current service users via social media would, almost certainly, represent an inappropriate breach of therapeutic boundaries, and as such a friend request from current service users should be politely declined. If clinical psychologists do interact with former service users via social media in a personal/social capacity then there are a number of issues which must be carefully considered. Firstly, is clearly important to recognise that interaction via social media is within the same ethical parameters as other forms of interaction. The key principles of professional guidance are that the professional relationship and position of trust should not be exploited; the BPS *Code of Ethics and Conduct* (2009) states that psychologists should 'Refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust' (paragraph 4.3 (i)). In addition to this clear prohibition, the principle of non-exploitation implies that clinical psychologists should refrain from accepting gifts of monetary value or accepting favours in kind from service users.

Furthermore, it would never be appropriate to enter into a social relationship with a former service-user who is a child; where clients are from a vulnerable or 'high risk' group extreme caution would be expected, as there could be issues of abuse of power, consent, potential risks to the psychologist and others.

Finally, clinical psychologists should continue to be mindful of their duty in respect to service user confidentiality. If they were to accept an invite to join a former service user's social network (e.g. on Facebook), they would need to be extremely alert about the significant risk that they could inadvertently breach the service user's confidentiality in their interactions via social media. It is therefore advised that clinical psychologists exercise caution and carefully consider these issues before interacting with current or former service users via social media.

If clinical psychologists interact with service users via social media they should communicate clearly with regards to the nature of the relationship. Interaction with current or former service users via social media in a personal/social capacity should only be undertaken with caution and after careful consideration of the relevant professional and ethical issues.

4) Interactions between colleagues within professional and educational settings

The points that have been made in the section above could also apply about relationships with professional colleagues and managers, or between university staff and postgraduate trainees. Within this there are subtle differences and nuances (for instance, the situation where people may be both friends and colleagues) but in addition there is an evaluative component as one is the manager or supervisor/assessor of another. Meridian (2012) refers to unpublished research across a range of institutions that indicated a lack of guidelines available for trainees compared to those in professional employment and suggests that e-professionalism is especially relevant for students in professional training who have to deal with a blurred border between being a student and a professional identity, and feels it is even more so when the area of training is client centred as this requires special consideration of their own and clients' privacy and safety.

The DCP does not have specific guidance at this stage, but would have an expectation that clinical psychologists would be thoughtful about these issues and that they openly discuss them with anyone with whom they were in an evaluative role. The DCP recommends that clinical psychology training programmes find appropriate opportunities to educate and reflect on these issues with trainees and that staff in an evaluative role with trainees/colleagues are transparent about their own stance about the use of social media with colleagues.

Interactions between colleagues within professional and educational settings can also raise issues and dilemmas particularly where there are power imbalances and an evaluative component. It would be expected that individuals and training courses would ensure that this is addressed transparently and reflectively.

5) Research

It is now feasible and thus more common to use social media such as Facebook to advertise research studies and recruit participants. Whilst this has many positive aspects, there are ethical and procedural issues which should be considered.

The APA and BPS provide guidance on using the web for research as well as guidance about the use of web surveys.

There may be a requirement to gain ethical approval for using social media as part of some research and this may necessitate the submission of advertisement and the descriptions of recruitment strategies.

If recruiting via social media it is important to obtain any necessary permissions, e.g. from a site moderator before posting advertisements for research, etc. on public or even restricted sites, even when the researcher is a member, as there are often rules that are not necessarily very obvious unless the researcher asks.

As mentioned earlier, it is strongly advised that a separate profile is created on the relevant site to use for research purposes in order to keep the boundaries clear.

Whilst conducting research using social media has many advantages and is to be welcomed, there are some practical and ethical issues that can arise, which may require advice from more experienced colleagues.

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APPENDIX 7: HEALTH AND SAFETY IN THE RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

Accident reporting

In the event of an accident, incident or near miss you should obtain an accident report form from the Secretary in the General Office. Complete and return to the Secretary to send on to the DSO. All accidents must be reported, no matter how minor.

Accident investigation

In the event of a serious accident as little as possible should be handled or moved and the accident must be reported at once to the HoD/DSO, who will notify the College Safety Office and arrange for a full investigation to be carried out.

The Joint Course Directors, in consultation with the DSO, will investigate all reported accidents, institute any follow-up action required and ensure that appropriate action is taken to prevent similar accidents in the future.

In the event of a serious accident/incident as little as possible should be handled or moved, any equipment or product (including disposable items) involved in an accident or incident must be retained and where possible left *in situ*, pending investigation.

After-hours and Lone Working

Out of hours working is defined as before 9.00 am and after 7.00pm weekdays, anytime at the weekend and College closures. In the event of members of the Department needing to work out of hours, it is essential for them to inform the Departmental Administrator Head of Department of their intention, and Security of their presence and departure.

Co-operation with other Organisations

Staff and students working in other organisations are required to comply with the host organisation's arrangements for safe working. The Department holds a record of names of all contacts in other Organisations. Supervisors are responsible for ensuring there are safe working procedures in place for any of their staff or students who are required to undertake work in environments controlled by other organisations.

Faulty Equipment

All staff are required to take immediate action concerning all confirmed or suspected safety-related defects and report their findings to the Secretary.

The equipment must be to be taken out of use until repaired or replaced.

Repairs will be dealt with by an approved contractor or the manufacturer.

Emergency Situations
In the event of a serious accident requiring an ambulance, violence/threat of violence, discovering a fire, phone in the first instance extension 41897/or out of hours emergency extension 222.

In the event of electrical mains failure or smell of mains gas phone ext 41897, out of hours ext 222.

Emergency instruction sheets are displayed in each teaching room and on appropriate notice boards.

Fire Safety
All staff and students should familiarise themselves with exit routes and assembly areas to be used in the event of fire. Information sheets are displayed as above. In the event of fire, phone ext. 45950/41896. Fire Marshals are Sandrine Callender, Will Fitzmaurice, Fatima Leitao.

Fire doors must not be wedged open, and corridors should be kept clear and not used for storage of excess furniture or equipment.

First Aid
After hours approach UCH Accident & Emergency Department. In the event of a serious accident call an ambulance via 222, stating name, location and contact no.

First Aid boxes are located in the following places: on top shelf, in the General Office, Room 436.

Housekeeping
The initial responsibility for the maintenance of housekeeping or tidiness in any office, both of themselves and of others, lies with its occupants. All members of the Department should exercise their common sense in terms of avoiding obvious health and safety hazards, e.g. trailing wires, unstable filing cabinets, large accumulations of rubbish, computer boxes or waste from eating and drinking.

Pregnant Workers
Pregnant Workers are defined as those who are: pregnant; have given birth within the previous six months after at least 24 weeks pregnancy (whether the baby survived or not); or are breast feeding. Pregnant Workers are entitled to a Risk Assessment of their work activities, a form will be sent by the Personnel Division whenever the worker informs them in writing that she is pregnant. Information on safe working during pregnancy is available from the Occupational Health Service ext. 32802. An information leaflet outlining the procedure is available from the DSO/dept notice board or in confidence from the Safety Office ext. 46363.

Smoking, Eating and Drinking
No smoking is allowed in any part of the building. Eating and drinking are only permitted in personal offices and common rooms and must never take place in the laboratory or any other area where chemicals are used, including offices which are part of laboratory areas.

In addition smoking, eating, drinking, or application of cosmetics are prohibited in all laboratory areas.

Use of laboratory equipment for the storage, refrigeration, freezing, heating, cooking or processing of food for human consumption is strictly forbidden.

Storage Arrangements
Corridors and means of escape must not be used for storage.

Where possible heavy or bulky items should be stored at waist height.

Unattended and Overnight Experiments
Unattended and Overnight Experiments must only be conducted with the permission of the Director of the Sub-Department and must be fully assessed for risks arising from their being unattended.

Violence
Report any incident immediately to Security on ext. 41262 stating name, location and circumstance.

Inform DSO/HoD of incident and fill in an accident/incident form.

Waste Disposal
All waste will be disposed of in accordance with College Policy using colour coded bags or other designated containers, e.g. 'sharps' containers.

Domestic and Office waste - black plastic sacks.

Recycling – there are designated recycling bins in the common room and in the corridor outside room 452 (photopier room).

Broken glass - put in a cardboard box, seal securely and label, thereafter as domestic waste (as appropriate).

Waste boxes, bulky rubbish, electrical equipment, fridges/freezers, should only be disposed of after direct agreement with Domestic Services ext. 37001. These items must not be stored/left in corridors pending collection.

Chemical - by arrangement with Hazardous Waste Service (x 46950)

The different types of waste must be segregated at all times. Bags must be sealed (knotted or taped, not stapled) at the point of origin and labelled with the name of the Unit concerned.

NHS

THE NHS CONSTITUTION

the NHS belongs to us all

for England
26 March 2013

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.
It touches our lives at times of basic human need, when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

This Constitution establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities**, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities. Where there are differences of detail these are explained in the Handbook to the Constitution.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

1. Principles that guide the NHS

Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public. These values are set out in the next section of this document.

1. The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The NHS aspires to put patients at the heart of everything it does. It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves. The NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

2. NHS values

Patients, public and staff have helped develop this expression of values that inspire passion in the NHS and that should underpin everything it does. Individual organisations will develop and build upon these values, tailoring them to their local needs. The NHS values provide common ground for co-operation to achieve shared aspirations, at all levels of the NHS.

Working together for patients. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives. We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts. We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

3a. Patients and the public – your rights and NHS pledges to you

Everyone who uses the NHS should understand what legal rights they have. For this reason, important legal rights are summarised in this Constitution and explained in more detail in the Handbook to the NHS Constitution, which also explains what you can do if you think you have not received what is rightfully yours. This summary does not alter your legal rights.

The Constitution also contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but represent a commitment by the NHS to provide comprehensive high quality services.

Access to health services:

You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

You have the right to access NHS services. You will not be refused access on unreasonable grounds.

You have the right to expect your NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.

You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.

You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.

The NHS also commits:

- to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge);
- to make decisions in a clear and transparent way, so that patients

and the public can understand how services are planned and delivered (pledge); and

- to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them (pledge).

Quality of care and environment:

You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.

You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.

The NHS also commits:

- to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge);
- to identify and share best practice in quality of care and treatments (pledge); and
- that if you are admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution (pledge).

Nationally approved treatments, drugs and programmes:

You have the right to drugs and treatments that have been recommended by NICE[1] for use in the NHS, if your doctor says they are clinically appropriate for you.

You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.

You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

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[1] NICE (the National Institute for Health and Care Excellence) is an independent organisation producing guidance on drugs and treatments. 'Recommended for use by NICE' refers to a type of NICE recommendation set out in legislation. The relevant health body is obliged to fund specified NICE recommendations from a date no longer than three months from the publication of the recommendation unless, in certain limited circumstances, a longer period is specified.

The NHS also commits:

- to provide screening programmes as recommended by the UK National Screening Committee (pledge).

Respect, consent and confidentiality:

You have the right to be treated with dignity and respect, in accordance with your human rights.

You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.[2]

You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.

You have the right of access to your own health records and to have any factual inaccuracies corrected.

You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

You have the right to be informed about how your information is used.

You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

The NHS also commits:

- to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively (pledge);
- to anonymise the information collected during the course of your treatment and use it to support research and improve care for others (pledge);
- where identifiable information has to be used, to give you the chance to object wherever possible (pledge);
- to inform you of research studies in which you may be eligible to participate (pledge); and
- to share with you any correspondence sent between clinicians about your care (pledge).

Informed choice:

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.

[2] If you are detained in hospital or on supervised community treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.

You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.

You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.

The NHS also commits:

- to inform you about the healthcare services available to you, locally and nationally (pledge); and
- to offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the range and quality of clinical services where there is robust and accurate information available (pledge).

Involvement in your healthcare and in the NHS:

You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate this right includes your family and carers.

You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

The NHS also commits:

- to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services (pledge);
- to work in partnership with you, your family, carers and representatives (pledge);
- to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one (pledge); and
- to encourage and welcome feedback on your health and care experiences and use this to improve services (pledge).

Complaint and redress:

You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.

You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.

You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.

You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.

You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.

You have the right to compensation where you have been harmed by negligent treatment.

The NHS also commits:

- to ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment (pledge);
- to ensure that when mistakes happen or if you are harmed while receiving health care you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again (pledge); and
- to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge).

3b. Patients and the public – your responsibilities

The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly.

Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.

Please treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.

Please provide accurate information about your health, condition and status.

Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.

Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.

Please participate in important public health programmes such as vaccination.

Please ensure that those closest to you are aware of your wishes about organ donation.

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

4a. Staff – your rights and NHS pledges to you

It is the commitment, professionalism and dedication of staff working for the benefit of the people the NHS serves which really make the difference. High-quality care requires high-quality workplaces, with commissioners and providers aiming to be employers of choice.

All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress. Care professionals should be supported to maximise the time they spend directly contributing to the care of patients.

The Constitution applies to all staff, doing clinical or non-clinical NHS work – including public health – and their employers. It covers staff wherever they are working, whether in public, private or voluntary sector organisations.

Staff have extensive **legal rights**, embodied in general employment and discrimination law. These are summarised in the Handbook to the NHS Constitution. In addition, individual contracts of employment contain terms and conditions giving staff further rights.

The rights are there to help ensure that staff:

- have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;
- have a fair pay and contract framework;
- can be involved and represented in the workplace;
- have healthy and safe working conditions and an environment free from harassment, bullying or violence;
- are treated fairly, equally and free from discrimination;
- can in certain circumstances take a complaint about their employer to an Employment Tribunal; and
- can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.

In addition to these legal rights, there are a number of **pledges**, which the NHS is committed to achieve. Pledges go above and beyond your legal rights. This means that they are not legally binding but represent a commitment by the NHS to provide high-quality working environments for staff.

The NHS commits:

- to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability (pledge);
- to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);
- to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential (pledge);
- to provide support and opportunities for staff to maintain their health, wellbeing and safety (pledge);
- to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge);
- to have a process for staff to raise an internal grievance (pledge); and
- to encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998 (pledge).

4b. Staff – your responsibilities

All staff have responsibilities to the public, their patients and colleagues.

Important legal duties are summarised below.

You have a duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

You have a duty to take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

You have a duty to act in accordance with the express and implied terms of your contract of employment.

You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

You have a duty to protect the confidentiality of personal information that you hold.

You have a duty to be honest and truthful in applying for a job and in carrying out that job.

The Constitution also includes **expectations** that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care.

You should aim:

- to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole;
- to take up training and development opportunities provided over and above those legally required of your post;
- to play your part in sustainably improving services by working in partnership with patients, the public and communities;

- to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff[3] or the organisation itself, at the earliest reasonable opportunity;
- to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment;
- to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation;
- to contribute to a climate where the truth can be heard, the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made;
- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care;
- to take every appropriate opportunity to encourage and support patients and colleagues to improve their health and wellbeing;
- to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care;
- to inform patients about the use of their confidential information and to record their objections, consent or dissent; and
- to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

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[3] The term 'staff' is used to include employees, workers, and, for the purposes of the Public Interest Disclosure Act (PIDA), agency workers and general practitioners who meet the wider PIDA definition of being a 'worker' (e.g. those performing general medical services under General Medical Services Contracts). Whilst volunteers are not covered by the provisions of PIDA, guidance to employers makes clear that it is good practice to include volunteers within the scope of organisations' local whistleblowing policies.

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SECTION 6, APPENDIX 1:
CONSENT FOR PARTICIPATION IN CLINICAL TEACHING

Background: Possible stresses linked to clinical teaching
For the most part trainees tell us that their teaching programme is stimulating and interesting. However, because of its aims and its focus, training in Clinical Psychology can present personal challenges to trainees – it is widely recognised that clinical teaching can be stressful. At some point in their training it is quite likely that trainees will feel uncomfortable or upset by material to which they are exposed. While this is often a transient experience, some trainees may experience a more sustained impact. The “triggers” for this upset might occur when:

- trainees recognise some aspect of themselves in the clinical material
- teaching makes them more uncomfortably aware of long-standing mental health issues which they had previously managed well
- some of the issues being discussed echo current dilemmas or life-events (such as bereavement, or relationship difficulties)
- some of the content of teaching is at variance with the trainee’s personal, cultural or religious beliefs or values

Teaching on the Course is not restricted to passive listening; it also involves active participation in exercises which many trainees find rather stressful. For example, most people find it somewhat exposing to role play in front of their peers, to disclose personal feelings, or to discuss their personal viewpoints, all things which often occur in experiential sessions, or in sessions where the focus is on feelings about professional work and career development.

Focusing on the ways in which teaching could be stressful is not intended to indicate that there is any intent to make it so. When planning training the Course takes into account the potential impact of the teaching content and the teaching method, especially when the topic is a sensitive one. We know that learning is inhibited by high levels of stress, which means that there are powerful educational reasons for keeping any stresses at an optimal level. All teaching is overviewed by the Curriculum Committee which receives direct feedback from trainees not only on teaching content but also on the appropriateness of teaching methods for every session. In that way we quickly learn what approaches wrok, and which don’t.

Support for trainees

Although we expect trainees to be appropriately robust in relation to the issues which training throws their way, we also expect them to be able to reflect on and to talk about their feelings – all of us need to recognise when seeking support from others is the most appropriate action. The Trainee Handbook contains clear information about sources of support. Although it can be very hard to draw the Course's attention to difficulties, suffering in silence is not helpful, and not a good model for a professional career.

Consent to participation in clinical teaching

It is a requirement of the Health Professions Council that when students participate in clinical teaching they have given informed consent to this. For this consent to be meaningful it is important to set out the Course's expectations, and the rights of trainees.

Course expectations in relation to clinical teaching

The Course expects that trainees will actively participate in all aspects of the academic programme, including:

- Lectures
- Experiential exercises which take place as part of lectures
- Workshops on clinical topics
- Seminars (including clinical seminars, academic seminars, reflective practice seminars and modality specific clinical seminars)
- Role-play as part of the above activities (including taking the role of both therapist and client)

Where a trainee finds participation difficult they are entitled to withdraw, but the Course expects them to do this in an appropriately professional manner. If their level of personal distress is very high and results (for example) in prolonged withdrawal from specific areas of teaching, it is expected that the trainee take appropriate action. This would normally include discussion with their Course Tutor, who can arrange for them to be exempted from teaching activities, and who will also discuss the most suitable strategies for managing the situation.

In practical terms, trainees who find themselves distressed during a lecture or a workshop are entitled to leave, but should do so as quietly as possible, returning if they feel able to, and if possible discussing their absence with the lecturer or workshop leader. Trainees who feel that a workshop task is too personally demanding are entitled not to participate, but should do so in an appropriately negotiated manner, if possible discussing this with the workshop leader.

Disclosure of personal information

During academic teaching there should be no pressure on trainees to disclose personal information which they feel uncomfortable revealing and especially personal information which they do not see as relevant to the task of training. However, the nature of the programme means that discussion of personal feelings in relation to professional development is often appropriate and necessary, and there is an expectation that trainees will be open to discussion of these feelings if these are relevant to their clinical work and professional development.

Confidentiality

Trainees who discuss their experience of stress arising from clinical teaching (or indeed any personal issue) with a member of staff are entitled to the usual assurance of confidentiality that applies in clinical contexts. This means that information that they disclose will not usually be discussed with third parties without their consent and/or knowledge. As in clinical contexts, a guarantee of confidentiality cannot be absolute, as might be the case if there were serious concerns about the welfare of the trainee. Any such breaches would be rare, and would usually be discussed with the trainee.

The HPC publish guidance relating to confidentiality on their website (the document is entitled ‘Confidentiality – Guidance for registrants’), and this expands on the principles set out in this paragraph.

Consenting to participate clinical teaching

At the end of this document is a formal consent form. Signing it means that trainees acknowledge and accept the expectations set out above. Because these make it clear that there may be circumstances where they might wish to withdraw from clinical teaching, it should be clear that while they are consenting to participate in teaching this consent is not absolute, and includes the right to withdraw if there are good grounds for doing so.

“Informed consent” means that trainees are not obliged to sign this form. If they have any queries about it they are free to discuss it and its implications with their Course Tutor.

Doctorate in Clinical Psychology

Consent to participation in clinical teaching

	please indicate with a cross
I have read the background information provided by the Course which: a) acknowledges the potential stresses inherent in clinical teaching b) sets out the Course’s expectations of trainees in relation to their participation in clinical teaching	

	please indicate with a cross
I am aware that I am not obliged to sign this form.	

	please indicate with a cross
I am aware of the relevant sections of the Trainee Handbook which describe the sources of support offered by the course and by external agencies.	

I consent to participate in the clinical teaching provided by the University College London Doctorate in Clinical Psychology

Name of trainee:

Signature: Date:

SECTION 6, APPENDIX 2:
CLINICAL SEMINARS - AIMS, CONTENT AND STRUCTURE

Aims of clinical seminars
Clinical seminars offer a regular forum for trainees to present, discuss and reflect on the clinical work they are undertaking on placement. The aim is to encourage discussion of this material from a clinical and a professional perspective. The remit is broad, and topic areas include:

- the development of theory-practice links (identifying the ways in which psychological models and theories can help to understand the clinical material)
- the generation of hypotheses about the presentation and of potential formulations which could help to guide plans for intervention
- consideration of the social contexts and systems in which the client's presentation, referral and difficulties are located.
- consideration of the broader professional contexts within which casework takes place, and the impact of this on the presentation and the ways in which the intervention has progressed
- consideration of the acceptability of the intervention for service users and whether the service context itself might influence the ways in which clients present and respond to treatment
- consideration any professional and ethical issues raised by the casework, cross-referring to the HPC and BPS codes of conduct and ethical practice

While not all these topics will be considered in every seminar, the seminar group should hold them in mind and ensures that where pertinent to the case they are discussed in appropriate depth.

The overarching aim is to support trainees in their capacity to think deeply about clinical work. However, the intent is to complement but not to substitute for or conflict with, the supervision offered to the trainee on their placement. The seminars also give trainees an opportunity to practise formal clinical presentations and to develop their capacity to communicate complex clinical material in a clear and concise manner.

Content
Because trainees present clinical material from their current placement, over the course of the three years seminar content will encompass a wide range of clinical populations, clinical contexts and clinical approaches.

While there is no bar on presenting casework which is going well and which the trainee and their supervisor feel they understand well, the seminars are more likely to be productive if trainees present cases they experience as challenging in some respect, and can hence take advantage of the opportunity for in-depth discussion afforded by the seminar.

At all times trainees will need to abide by relevant Trust and professional codes and ensure that client confidentiality is preserved, where possible gaining formal consent for the presentation from relevant parties. At times consideration of these issues may need to become the focus of at least part of the seminar discussion.

Role of the facilitators
Each seminar group has two facilitators, one from within the course (usually a Clinical Tutor) and one a supervisor from the region (usually paired so as to be able to represent more than one clinical model or client group). Their role is to encourage and guide discussion in order to help the group achieve the learning aims outlined above. This may require them to be sensitive to the group process and to ensure that any potential barriers to open discussion (such as tensions between group members) are addressed and as far as possible resolved.

Structure of the Clinical Seminars
The way in which the seminar is structured and the number of presentations per seminar will be for the seminar group and facilitators to decide. However, case presentation should be fairly formal, including an outline of the case and relevant background details, along with an indication of the areas the presenter feels they would like to focus on (for example, a clinical dilemma, ethical issue, professional/team issues, general case formulation, or more specific formulation of an impasse, etc). Immediately after the seminar facilitators will give feedback to the presenter on their presentation skills.

Assessment
Although a compulsory element of the Course there is no formal evaluation of the trainee’s contribution to the seminar.

Opportunities for feedback on, and review of, the seminar
At the end of each year seminar group members give formal feedback to the course and this is collated by the individual organising seminars, passed to the Academic Director and considered by the Curriculum Committee and the Course Monitoring Committee.

It makes sense for facilitators periodically to ask the group for comment on their experience of the seminar and its helpfulness and whether any changes are required in order to ensure that the group is functioning in a manner congruent with the seminar aims.

SECTION 8, APPENDIX 1:
BPS GUIDELINES ON CLINICAL SUPERVISION

The following is adapted from the BPS criteria for the Accreditation of courses.

1 Qualifications of supervisors

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.

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.

2 Types of supervisory arrangements

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:

> that each trainee must have a named supervisor who is responsible for the co-ordination of their supervision and who formally assesses the trainee in consultation with the other supervisor(s) involved;
>
> that individual supervision must provide opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as on-going case work.

3 Supervisors' workshops and meetings

Courses should organise regular supervision workshops to train supervisors in methods of supervision; these should be designed with the needs of new as well as experienced supervisors in mind. Supervisors are expected to attend workshops on supervision. There should also be regular meetings at which supervisors have an opportunity to share information and discuss problems.

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

4 Allocation to clinical placements

There should be an explicit procedure for allocating trainees to clinical placements. All trainees and supervisors involved should understand the procedure and know how to influence decisions about clinical placements. The person responsible for arranging placements should give primacy to general training requirements but should also take account of the needs and interests of individual trainees. Information should be provided about the experience obtainable in the various placements to help trainees and course staff make placement decisions; trainees' interests need to be taken into account in the allocation of specialist placements.

5 Setting up the placement

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

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

Although physical resources within the health service and other public services are frequently inadequate, care should be taken to ensure that the trainee has access to (at least) shared office space and a desk. There should be adequate arrangements for secretarial support for placement work and trainees should be given guidance on the facilities available.

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

6 Placement content

Guidelines for the content of particular placements are provided in the Criteria for the Assessment of Courses. Course training committees should expand and operationalise these in consultation with supervisors.

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

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

A log should be kept of the work a trainee has done in a clinical placement. The Course should ensure that these records are appropriately used by the placement co-ordinator in planning future placements and by future clinical supervisors in discussing what experience they should provide.

7 Clinical supervision

The supervisor and trainee should meet each week for a formal, scheduled supervision tutorial; this should be of at least an hour's duration. Longer supervision will usually be needed. In addition, supervisors should try to make themselves available for informal discussion of matters that arise between formal supervision sessions. The total contact between the trainee and supervisor should be at least three hours a week, and will need to be considerably longer than this at the beginning of training.

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

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

8 Quality of clinical supervision

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

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

Trainees and supervisors may find that they have a different orientation and interests. Where this happens, tolerance should be shown on both sides. Trainees should be helped to see that they may learn much that is valuable from a supervisor whose approach they may not ultimately wish to adopt. On the other hand, supervisors should see it as one of their functions to help trainees develop their own interests in an appropriate way. Where supervisors decide they must overrule the way the trainee wishes to work, they should explain their reasons with care, rather than simply asserting that this is how things should be done. If trainees can present sound reasons for adopting a different approach, the supervisor should be prepared to support this unless he or she has serious doubts about its effectiveness or the possibility of harm to clients.

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

9 Clinical reports and communication

Communication with other members of clinical teams and networks involves both written and verbal reports. Verbal reporting and discussion are often more important than formal written reports in terms of their effects on clinical decisions and action. Since the relative importance of written and oral communication is likely to vary between settings, supervisors will need to identify the most important channels of communication in their placement and teach the trainee to use these channels effectively and efficiently.

Training in effective communication will involve both observation of the supervisor's behaviour, and practice by the trainee with ample opportunity for feedback.

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

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

10 Assessment of clinical competence

It is important that Supervisors are familiar with the examination and continuous assessment requirements for trainees and the guidelines and regulations for these. Supervisors should be familiar with the specific criteria for passing and failing placements set by the Course. In addition, supervisors should be familiar with appeals procedures. In cases where trainees have displayed unsatisfactory behaviour, such as regular and serious lateness for clinical appointments, professional misconduct, or failure to acquire an adequate level of clinical competence, trainees should be left in no doubt about the problem. The supervisors should discuss with the placement co-ordinator what action should be taken and it may be helpful to have a member of the Course staff present at the time of the end of placement review.

SECTION 8 APPENDIX 2

The
British
Psychological
Society

Division of Clinical Psychology
Faculty for Children and Young People

Good Practice Guidelines for UK Clinical Psychology Training Providers

Training and consolidation of clinical practice in relation to children and young people

Purpose and status of this document

This document has been prepared on behalf of the Faculty for Children and Young People. The document is intended to guide training providers and members of the profession in ensuring that newly-qualified clinical psychologists who may be employed to work with children and families are able to meet the needs of children, young people and families across the range of children's services and contexts. Furthermore, the document aims to provide guidance to ensure clinical psychologists are competent to meet the needs of children, when issues of a child in need arise in other service contexts. An example of this might be when a clinical psychologist working with an adult in Adult Mental Health Services is confronted with a child protection issue.

More and more child clinical psychologists are working in diverse and specialist service settings such as forensic, and in agencies outside of the National Health Service (NHS) such as Social Services. It is the opinion of the Faculty that training programmes should take this into account when preparing trainees who may be considering work with children when qualifying.

This guidance is also intended to aid in planning and evaluating the consolidation of experience and competences of newly-qualified clinical psychologists working with children and young people prior to transition from Agenda for Change band 7 to band 8.

This document has been approved by the Division of Clinical Psychology (DCP) Training Strategy Group (TSG) for publication and circulation by the DCP.

Introduction

This document has been prepared in the light of recent publications: The National Service Framework for Children, Young People and Maternity Services (2004), 'Every Child Matters' (2005) and the Children Act (2004).

The National Service Framework (NSF) sets out three key objectives, namely to put children and their families at the centre of care; to develop effective partnership working so that the needs of the child are always considered; and to deliver needs led services (DoH, 2004).

The NSF emphasises five core standards:

- Promoting health and well-being, identifying needs and early intervention;
- Supporting parenting;
- Child, young person and family centred services;
- Growing up into adulthood;
- Safeguarding and promoting the welfare of children and young people.

Similarly 'Every Child Matters' specifies five principles to service provision; that children should be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic well-being.

The NSF further stipulates an increase in child and adolescent mental health services by at least 10 per cent according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment). It is the Faculty's view that training programmes should take this into account in the planning and structure of training in order to reflect workforce planning requirements within the NHS. Furthermore, it is a requirement of the British Psychological Society (BPS) Accreditation Criteria for Training Programmes in Clinical Psychology to take into account workforce issues (Section B2.5, CTCP, 2002).

The Children Act (2004) raises issues of how professionals and agencies work together and introduces a duty on local authorities and other services to co-operate to improve the well-being of children.

BPS Accreditation Criteria for Training Programmes in Clinical Psychology

The criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology (CTCP, 2002) highlight that the initial training provides the foundation for the range of skills and knowledge demonstrated by the profession and that these skills are developed and consolidated through further professional development (Section B2.3). This document is intended to aid in planning and evaluating the consolidation of experience and competences of newly-qualified clinical psychologists working with children and families.

The criteria for accreditation requires that training programmes consult with DCP Faculties with regard to the development of the syllabus and preparing trainee clinical psychologists for clinical practice:

'Programmes should refer to the minimum standards which are identified and revised from time to time by the DCP faculties and SIGs for guidance in relation to the expected capabilities which a trainee should gain to fit them for work with specific populations and groups.' (Section A6)

'The national standards as set out by Faculties and SIGs will provide the reference information for the minimum supervised practice commensurate with competence in an area of work.' (Section 7.2)

'The development of the syllabus should be informed by consultation with the DCP Faculties and SIGs.' (Section 9.1)

The accreditation criteria further state that programmes may differ in their emphases and orientations but that trainee clinical psychologists are required to gain experience of working with people across the lifespan and should gain experience of working with children and young people and have teaching on children:

'A fundamental principle is that trainees must work with clients across the lifespan, such that they see a range of clients whose difficulties are representative of problems across all stages of development.' (Section B2.6.1)

'While it is appropriate that programmes should differ in their emphases and orientations, they must all provide academic teaching relevant to the full range of client groups and a wide range of clinical methods and approaches. This will include teaching on children, adults and older adults and cover mild, moderate and severe mental health problems, learning disabilities, sensory and physical handicaps, brain injury, alcohol and other drug problems and a range of physical health problems.' (Section 9.2)

Core Competences

Within the core competence framework as specified by the accreditation criteria the Faculty has drawn up a list of competences to assist training programmes in ensuring that trainees have acquired the necessary skills and have at least basic competence to meet the needs of children, young people and families.

Transferable Skills:

- Understanding of theories of child development and knowledge of developmental milestones, the ability to identify early warning signs of atypical psychosocial development.
- Have an understanding of the concepts of vulnerability and resilience with respect to children and families.
- Understanding of children's problems as nested within multiple systems including the child, the family, the school and the wider social network, and knowledge of the impact of parenting practices on the psychological development of children and young people.
- Be able to use the knowledge base of clinical psychology and prior experience to make informed judgements about clinical phenomena when working with children and families.
- Have knowledge of psychological interventions and demonstrate competence in applying these interventions to working with children and families and wider systems.
- Have an understanding of a lifespan perspective and transitions when working with children and families.

Psychological Assessment:

- To be able to communicate and engage with children and young people of different developmental stages using age appropriate language, play and other media, e.g. artwork.
- Be able to conduct an assessment in partnership with a family, engaging and involving all members of the family.
- Be able to select, administer and interpret psychometric assessments with pre-school children, primary school-aged children and adolescents.
- Be able to obtain information from the wider system to inform an understanding of the child's difficulties in the context of the family, school, community and culture.
- Be aware of issues of risk and child protection when assessing children and families and be able to gather appropriate information in order to make a risk assessment, appropriate decisions regarding risk and risk management.

Psychological Formulation:

- Work collaboratively with children and families using a range of psychological models (e.g. cognitive-behavioural, systemic, behavioural, etc.) to develop an understanding of the problems within the context of the family and wider system, taking into account development, gender, culture, economic and social factors.
- Be able to explain a psychological perspective clearly and meaningfully to others, including children, young people and their parents/carers and to other professionals who work with children and families.

Psychological Intervention:

- Based on a formulation be able to develop and implement a psychological intervention which addresses the systems relevant to the maintenance of the child's presenting problem.
- Be able to develop an intervention plan in collaboration with parents, carers and children and to set achievable and realistic goals.

Psychological Evaluation:

- Be able to systematically evaluate interventions with children, parents/carers and to modify the formulation and intervention in response to evaluation feedback.
- Be aware of clinical audit measures for children and models of service evaluation, including the difference between individual outcome measures and population targets and outcomes.

Research:

- Be able to plan, execute and evaluate clinical research, which addresses childhood and adolescent difficulties and be able to show an understanding of the specific ethical issues in research with children.

Personal and Professional Skills:

- Have an understanding of ethical issues when working with children, young people and families and an ability to apply these in complex clinical contexts.
- Demonstrate an understanding of informed consent and the implications for working with children, young people and families.
- Be aware of issues of confidentiality when working with children, young people and families, and complex service systems.
- Have knowledge of local and national guidelines and policies which inform professional practice when working with children and families, in particular child protection policies, National Service Framework and NICE Guidelines.

- Awareness and respect for diversity and difference when working with children, young people and families.
- Be able to use supervision and in particular have an awareness of the impact of working with children at risk, and the need for support and supervision.

Communication and Teaching:

- Demonstrate an ability to communicate with children and young people and their families both in writing and face to face, and adapt communication to meet the needs of the recipient.
- Be able to present a psychological perspective to a range of professionals in children's services including a multi-disciplinary team and in multi-agency settings.

Service Delivery:

- Understand the specific legal and statutory frameworks applicable to children.
- Be able to demonstrate an understanding of the key principles and practices of government legislation and the implications for the delivery of services for children and families.
- Have an understanding of Child Services and the tiers of service delivery.
- To understand and respect the roles and responsibilities of different service providers for children and families (including health, social services, education and the voluntary sector) and work in collaboration with them in delivering psychological interventions.
- Have an understanding of consultancy and be able to use psychological models in liaison and consultation with carers and professionals across a range of service settings.
- Use psychological principles and models to develop innovative services for children and families.

Mechanisms for achieving competences

All training programmes should ensure that they provide trainees with the experiences and opportunities needed to develop the competences outlined in this document through a mixture of academic teaching and clinical placement experience.

In line with the accreditation criteria it is the view of the Faculty that each training programme should have specialist teaching on children and young people, which covers knowledge and skills specific to working with children as well as teaching which integrates thinking about children in relation to other specialties. Training courses should pay particular attention to the assessment of competence development.

The Faculty recognises that trainees may be able to acquire some of the competences outlined above with other client groups and in a range of service contexts. However, in order to be able to integrate knowledge, skills and clinical experiences, trainees should gain substantial experience within the context of a children and young people service, which ideally would be in the form of a dedicated placement. Alternatives to this model of gaining experience with children should only be considered in consultation with local child specialty supervisors to ensure trainees gain sufficient clinical experience to develop competence in working with children and families and to meet local workforce planning needs.

Review Process

These guidelines will be reviewed in 2010, at which point CPD requirements should also be considered, including type of competences and experiences that should be consolidated in the first 18 months post-qualification.

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Appendix 1: Members of the Working Group

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Appendix 2: Consultation Process

An initial draft of this document was circulated in November, 2005, to the National Committee of the DCP Faculty for Children and Young People.

The draft was then circulated to the membership of the Faculty for Children and Young People in January, 2006.

Comments received which suggested a consensus or were based on convincing arguments were incorporated into this final document.

The British Psychological Society was founded in 1901 and incorporated by Royal Charter in 1965. Its principle object is to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge.

The Society has more than 42,000 members and:

- has branches in England, Northern Ireland, Scotland and Wales;
- accredits around 800 undergraduate degrees;
- accredits over 150 postgraduate professional training courses;
- confers Fellowships for distinguished achievements;
- confers Chartered status for professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 10 scientific journals and also jointly publishes *Evidence Based Mental Health* with the British Medical Association and the Royal College of Psychiatrists;
- publishes books in partnership with Blackwells;
- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through the *Appointments Memorandum* and *www.appmemo.co.uk*;
- provides a free ‘Research Digest’ by e-mail;
- publishes newsletters for its constituent groups;
- maintains a website (*www.bps.org.uk*);
- has international links with psychological societies and associations throughout the world;
- provides a service for the news media and the public;
- has an Ethics Committee and provides service to the Professional Conduct Board;
- maintains a Register of more than 12,000 Chartered Psychologists;
- prepares policy statements and responses to government consultations;
- holds conferences, workshops, continuing professional development and training events;
- recognises distinguished contributions to psychological science and practice through individual awards and honours.

The Society continues to work to enhance:

- recruitment – the target is 50,000 members by 2006;
- services – the Society has offices in England, Northern Ireland, Scotland and Wales;
- public understanding of psychology – addressed by regular media activity and outreach events;
- influence on public policy – through the work of its Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership.

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The
British
Psychological
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Division of Clinical Psychology
Faculty for Learning Disabilities

Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Adults with Learning Disabilities

April 2012

Purpose and status of this document

This document has been prepared by a working group on behalf of the British Psychological Society's Division of Clinical Psychology (DCP) Faculty for Learning Disabilities. Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the needs of individuals with learning disabilities and their carers, in whatever setting or context they come into contact with them. This revision of the original guidance issued in 2005 recognises that clinical psychologists are now likely to provide support to individuals with learning disabilities and their carers both within specialist health services and within mainstream health and social care. Hence the guidance sets out the knowledge and skills that clinical psychologists should acquire over the course of their training that will enable them to provide person-centered, effective, safe and dignified assessments and interventions for adults with learning disabilities, their carers and the systems supporting them.

The Faculty believes that it is the responsibility of each training course in conjunction with regional Faculty groups and supervisors to work jointly towards these aims and to use the present guidance to these effects. This guidance is in line with the current Accreditation Guidance for Clinical Psychology Programmes (BPS, 2010), which notes that:

- Programmes should refer to the minimum standards which are identified and revised from time to time by the Division of Clinical Psychology's Faculties for guidance in relation to the expected capabilities which a trainee should gain to fit them for work with specific populations and groups (p.13).
- National standards as set out by the DCP's Faculties and Special Interest Groups must also guide training patterns for each cohort of trainees (Section A3.5).
- The development of the (teaching programme's) syllabus should be informed by consultation with DCP Faculties and Special Interest Groups (Section B6).
- The national standards as set out by the Division of Clinical Psychology's Faculties will provide the reference information for the minimum supervised practice commensurate with competence in an area of work. Based on this reference information programmes must develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. Programmes must identify gaps in placement experiences provided, both individual and across the trainee cohort, and plan how they will structure the pattern of clinical training to overcome any deficiencies (Section C2).

This document has been approved by the DCP Training Strategy Group (TSG) and is published and disseminated by the BPS.

Prepared by a Working Party on behalf of the Faculty for People with Learning Disabilities. Published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.
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1. Introduction

It is estimated that around 2.5 % of the UK population have learning disabilities. While they are a diverse group with a range of needs and wishes, collectively they are one of the most vulnerable groups in society (DCP Faculty for Learning Disabilities, 2011). It is now widely recognised that they are at markedly increased risk of developing mental ill-health and a significant number present with behaviours that pose serious challenges to services (DCP Faculty for Learning Disability, 2011; Judith Trust, 2012). As a result they are more likely than people without cognitive impairments to require the support of clinical psychologists. Historically the needs of people with learning disabilities have largely been addressed by specialist learning disability services. Over the past few decades though there has been an increasing emphasis on ‘mainstreaming’ and a shift away from segregated services. These developments are closely in line with the White Paper *Valuing People* (DoH, 2001), its revision, *Valuing People Now* (DoH, 2009), and similar legislation in the devolved nations, which emphasise four key principles: rights, independence, choice and inclusion. Furthermore the *Improving Access to Psychological Therapy* (IAPT) programme has had a major impact on the delivery of psychological therapy in England and Wales. As a result of these developments, clinical psychologists are likely to meet people with learning disabilities across a wide range of specialities and within both specialist health services and mainstream health and social care. However, the government’s aims to improve health outcomes and reduce inequalities in many cases remain a valued but distant ideal and there is now significant evidence that people with learning disabilities often experience problems accessing health care and equal treatment (DCP Faculty for Learning Disability, 2011). Thus there is a need to ensure that clinical psychologists in all specialities are well equipped to work with this client group, to know when a referral to specialist learning disability services is appropriate, and to know how to make, and help others to make, reasonable adjustments in line with the Disability Discrimination Act.

All support provided to individuals with learning disabilities should be person-centered, and should ensure that the service-user’s perspective is paramount at all times and central to any interventions considered, including when working with carers, members of other disciplines and support agencies. The number of instances over recent years where adults with learning disabilities were the victims of severe abuse at the hands of those in whose care they had been placed, indicate that safeguarding continues to be a major concern. Similarly there has been increasing attention to hate crimes committed against individuals with learning disabilities. It is the Faculty’s view that all psychologists need to have an understanding of this area, if they are to play a role in safeguarding individuals with learning disabilities, keeping them in their local communities and monitoring their welfare.

2. BPS Accreditation Guidance for Clinical Psychology Training Programmes

Historically many learning disability services experienced difficulties in recruiting clinical psychologists. While this is no longer the case, it is the Faculty’s belief that training courses should encourage trainees to consider specializing in this area post-qualification. In order to positively promote recruitment to the learning disabilities field, training courses should ensure that trainees have adequate placement experience with this client group and that misconceptions, which may result from lack of exposure rather than other factors, are challenged. As the inclusion of people with learning disabilities in mainstream health services continues to increase, the likelihood of clinical psychologists outside specialist learning disability services being asked to work with individuals with learning disabilities will also increase. This is already frequently the case, for example, in relation to IAPT or dementia care services.

The BPS Accreditation guidance further sets out required learning outcomes. It is the Faculty's view that learning disability services typically offer a working context that is particularly suited to enable trainees to develop the following learning outcomes specified in the accreditation criteria. The Faculty recognises that other services can also contribute to developing some of these learning outcomes, but is of the view that those marked with * are most likely to be met or can only be met in the context of specialist learning disability services:

Communication and Teaching (Section 2.3.8 of Accreditation Guidance, BPS, 2010)

- **Adapting styles of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.*
- *Preparing and delivering teaching and training which takes into account the needs and goals of the participants.*

Service Delivery (Section 2.3.9)

- *Understanding of consultancy models and the contribution of consultancy to practice.*
- *Understanding of leadership theories and models, and their application to service development and delivery.* NB: It is the Faculty's view that work in the context of multidisciplinary learning disability settings lends itself very well to developing leadership skills.
- *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.*

Clients (Section 3.6.1)

It is essential that trainees work with:

- *Problems ranging from those with mainly biological and/ or neuropsychological causation to those emanating mainly from psychosocial factors;*
- **Clients with significant levels of challenging behaviour;*
- **Clients across a range of levels of intellectual functioning over a range of ages, specifically to include experience with clients with developmental learning disabilities;*
- **Clients whose disability makes it difficult for them to communicate;*
- **Carers and families.*

Modes and type of work (Section 3.6.3)

- *Indirect, through staff and/or carers;*
- *Work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;*
- *Work (i.e. practice, teach, give advice) in at least two evidence-based models of formal psychological therapy.* NB: It is the Faculty's view that work with adults with learning disabilities lends itself very well to learning to adapt evidence based models to clients' communicative and cognitive capabilities and show flexibility where required.
- *Work with complexity across a range of perspectives, demonstrating flexibility in application of whichever approach is most appropriate for the client or system.*

The UK health care context and the application of clinical psychology (Section 3.6.4)

Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken, including:

- *Legislation relevant to England and the devolved nations* (e.g. *Mental Capacity Act*, Disability Discrimination Act*, Mental Health Act, Health and Social Care Act, Adults with Incapacity Act* (Scotland), *Adult Support and Protection Act* (Scotland)).

- *Government policy statements* NB: It is the Faculty's view that work in the field of learning disabilities lends itself very well to learning about the immediate influence of policy on service delivery, not least the policy statements *Valuing People* (DoH, 2001) and *Valuing People Now* (DoH, 2009) and guidance such as the *Mansell Report* (DoH, 2007) and *No Secrets* (DoH, 2000)

3. Required competencies, experiences and service settings

The Faculty for Learning Disabilities has drawn up a list of competencies to assist training providers in ensuring that trainees have acquired the learning outcomes specified in the Accreditation guidance and have at least a basic capability to meet the needs of people with learning disabilities, wherever they may come into contact with them in their professional practice. The competencies listed below are based on the national policy document *Valuing People* (DoH, 2001) and its revision *Valuing People Now* (DoH, 2009), more specific guidance issued for Scotland (*The Same as You*, Scottish Government, 2000) and Wales (*Policy and Practice for Adults with a Learning Disability*, Welsh Assembly Government, 2007) and the *Accreditation Guidance for clinical psychology programmes* (BPS, 2010). It should be noted that some of these competencies are very specific to a learning disabilities context and thus are unlikely to be achieved in other areas (these have been marked *). Other competencies laid out below are of a more generic nature and may be met through work in other specialities.

3.1* Understanding of the history and current context of services for people with learning disabilities, including: historical constructions of 'learning disability', the marginalisation and stigmatisation of people with learning disabilities, institutionalisation, normalisation; the social model of disability; and the continued failure to safeguard adults with learning disabilities against abuse by those in whose care they have been placed.

3.2* Understanding of current policies, particularly *Valuing People* and *Valuing People Now* (and their Welsh and Scottish counterparts, where relevant), and means of service delivery, including inclusive education, person centred planning, personalised care and the Care Programme Approach as it applies to this client group.

3.3* Appreciation of the heterogeneity of people classified as having learning disabilities and an understanding of classification and epidemiological issues.

3.4 Ability to work with people who may be very different from trainees and at high risk of social exclusion, together with the ability to reflect on such work and feelings evoked.

3.5 Awareness of the impact of difference and diversity as they may affect both service uptake and engagement with psychological work. This includes an awareness of the risks of multiple sources of discrimination, not least for people with learning disabilities and their carers who are social disadvantaged, from black and minority ethnic or newly arrived communities.

3.6* Understanding of the biopsychosocial model as it applies to this speciality, including an understanding of possible causes of learning disabilities, the interaction of biology and behaviour (including behavioural phenotypes), autistic spectrum disorders, and possible physical and mental health problems and disabilities co-occurring alongside learning disabilities (e.g. sensory impairments, dementia).

3.7* Understanding of the impact of having learning disabilities across the lifespan, which may include diagnosis and intervention during the childhood years, transition during late teenage and early adult years, adulthood and older age. Trainees should also develop some understanding of the potential impact on family and paid carers of caring for a person with learning disabilities.

3.8* Understanding of the different contexts of which people with learning disabilities may be part: i.e. the family; special and mainstream education in schools and colleges; day and leisure opportunities; vocational and employment opportunities; supported living schemes and residential care; and specialist care settings, such as inpatient generic and mental health settings, and forensic settings.

3.9* Ability to communicate, both face-to-face and in written/pictorial form, with people from across the whole spectrum of communication abilities, including individuals who are non-verbal, together with an awareness of communication issues and mediums to facilitate accessible communication.

3.10 Understanding of power differences between professionals and people who are marginalised or disempowered due to cognitive or communication deficits and how to address these in practice (e.g. minimising the risk of acquiescence, working psychologically in a less formal manner with individuals who have had aversive experience of formal settings).

3.11*Ability to adapt psychological assessments and interventions to the cognitive, communication, sensory, social and physical needs of people with learning disabilities and their carers.

3.12 Ability to complete a detailed functional analysis of behaviour and translate the results into appropriate guidelines which are sensitive to the needs of those implementing them, and recognise common barriers to successful implementation.

3.13*Ability to understand and respond to behaviour that challenges services in order to support people locally and reduce the likelihood of out-of-area placements. This will include an understanding of the role of positive behavioural support and ability to translate this into behaviour support plans.

3.14 Ability to develop multi-faceted formulations and interventions which take into account individual, systemic and organisational factors.

3.15 Ability to work with a range of service providers, including health, social services, education, the voluntary and private sectors.

3.16 Understanding of the potential vulnerability of adults from marginalised groups, knowledge of safeguarding policies and procedures, and ability to recognise signs of possible abuse.

3.17 Understanding of capacity and consent issues, ability to obtain informed consent and to contribute to multidisciplinary assessments relevant to capacity and, where a person is deemed to lack capacity, ability to sensitively inform ‘Best Interests’ procedures.

3.18 Ability to consult to diverse staff teams and adapt the communication of psychological theories and interventions to recipients’ needs.

3.19 Ability to contribute to service development.

3.20 Ability to work with colleagues in multidisciplinary teams, liaise effectively with other services and professions and demonstrate leadership where called for.

3.21 Ability to design and deliver teaching and training that is clear, effective and closely matched to learners’ needs.

4. Mechanisms for achieving these competencies

All clinical psychology training courses should ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 Academic Teaching

The Faculty believes that each academic programme must have a specialist learning disability component which covers knowledge and skills specific to work with people with learning disabilities, alongside teaching which integrates thinking about people with learning disabilities with other client groups in relation to specific clinical and contextual issues. Both specialist and integrated cross-speciality teaching which addresses the needs of people with learning disabilities should be developed and reviewed in regular consultation with the regional Faculty for Learning Disabilities group to reflect the views and needs of the speciality at both local and national level. Skills-based teaching should be delivered by clinicians specialising in the area of learning disabilities. Training programmes should aim to involve service users directly in teaching.

The Faculty recommends that each programme should cover the following areas as a minimum, either through specialist and/or integrated cross-speciality teaching:

- The history and current context of services for people with learning disabilities and current policies.
- Power differences between professionals and people with learning disabilities and how to address these in practice, and, where relevant, in research.
- The theory and practice of psychometric and adaptive functioning assessments.
- Current 'best practice' in establishing eligibility for learning disability services.
- The mental health needs of adults with learning disabilities.
- Adaptation of a range of therapeutic approaches, assessments and interventions to the needs of people with learning disabilities and their carers.
- Current perspectives on behaviours that challenge services, including positive behavior support.
- Functional analysis.
- Autism spectrum disorders, including causes, clinical presentations and appropriate interventions.
- A range of methods suitable for evaluating psychological work with people with learning disabilities.
- Capacity and consent issues and their implications for clinical practice.
- Supporting individuals with learning disabilities in relation to sexuality.
- Supporting parents who have learning disabilities.
- Dementia (including as it affects people with learning disabilities).
- Offending behavior in people with learning disabilities.
- The role of clinical psychology as part of providing good quality support to individuals with profound and multiple learning disabilities and their families (see Dept of Health, 2010)

4.2 Clinical Placements

The Faculty recognises that trainees may be able to acquire at least some of the competencies outlined above in a range of service contexts and with a range of client groups. However, it is the Faculty's belief that in order to be able to integrate their knowledge, skills and clinical experiences trainees should, wherever possible, gain substantial experience within the context of learning disability services. Wherever possible, this will be in the form of a dedicated learning disabilities placement. In considering any alternative arrangements to this model, clinical training courses and regional supervisors should jointly ensure that such arrangements will allow trainees to gain a thorough understanding of the context and heterogeneity as well as complexity of the client group. In any case training providers must ensure that trainees meet the minimum competences set out by the BPS accreditation guidance, above all they must have direct clinical experience of working with individuals with learning disabilities; those with significant levels of challenging behaviour; and individuals whose disability makes it difficult for them to communicate (see section 2. above).

Trainees' supervised experience should include the following, wherever possible, and in whatever clinical setting that can provide such experiences:

Trainees should have substantive experience with people with learning disabilities with a mix of presenting problems in a variety of service settings and, across the lifespan, should be exposed to individuals from across the spectrum of learning disabilities, including individuals with severe and profound learning disabilities. The Faculty sees the following placement experiences as essential in ensuring that trainees will be able to meet the needs of individuals with learning disabilities upon qualification:

- work relating to someone whose behaviour is constructed as 'challenging', involving a comprehensive functional analysis;
- work relating to someone with an autistic spectrum disorder;
- work with a person with severe or profound learning disabilities;
- at least one detailed psychological assessment, which should include the use of formal measures (e.g. psychometric or functional assessment), and which should at least partly be completed directly with a person with learning disabilities;
- at least one direct assessment and intervention involving a person with learning disabilities;
- at least one assessment and intervention with family or paid carers; this could include indirect work with a staff team; and
- formal evaluation of the impact of a piece of psychological work, whether assessment (and feedback) or intervention.

The Faculty recognises that some high quality, yet very specialist placements, may not provide the range of experiences outlined above. It is intended that these recommendations should serve as a template to guide course staff, supervisors and trainees. The precise meaning of 'substantive experience' should be judged on an individual basis, bearing in mind that the entire training experience should enable trainees to demonstrate achievement of the learning outcomes outlined in Section 2 and to acquire the competencies outlined in Section 3. In some cases these may be acquired through work with quite a number of clients, in others through much more in-depth work with a few clients, supplemented by observation, discussion and reflection. The range and types of experiences outlined above are of course not mutually exclusive, but several may be addressed in in-depth work with the same individual or care system.

5. Review Process

These guidelines should be reviewed in 2017.

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Comments on a draft were received from the national committee of the DCP Faculty for Learning Disabilities and from the DCP Professional Standards Unit.

SECTION 8 APPENDIX 3

PSIGE

The
British
Psychological
Society

Division of Clinical Psychology
PSIGE – Psychology Specialists Working with Older People

Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People

November 2006

Purpose and status of this document

This document has been prepared by the PSIGE Training Subgroup on behalf of PSIGE – The Faculty for Psychologists working with Older People. Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the needs of older people, in whatever setting or context they come into contact with them. The guidance within is also intended to aid in planning and evaluating the consolidation of experience and competences of newly qualified clinical psychologists working within the older peoples' speciality before transition from Band 7 to Band 8 within Agenda for Change.

The Faculty believes that it is the responsibility of each training course in conjunction with local Special Interest Groups and supervisors to work jointly towards these aims. This is in line with the current Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology (CTCP, 2002) that set out clear requirements for consultation with DCP Faculties in relation to:

- 'The expected capabilities which a trainee should gain to fit them for work with specific populations and groups' (Section A6).
- Provision of 'the reference information for the minimum supervised practice commensurate with competence in an area of work' (Section 7.2).
- And 'development of the syllabus' (Section 9.1).

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PSIGE is the Faculty for Old Age Psychology – www.psige.org

1. Introduction

Nearly a fifth (19.5 per cent) of people in the UK are aged 65 or older. They are consumers of 50 per cent of health and social care spending. Older people have at least equivalent rates of psychological distress generally as compared to younger people and show significant levels of depression and suicide as well as dementia.

However, just over five per cent of the Clinical Psychology workforce specialises in work with older adults (DoH and BPS National Workforce Survey 2003) and fewer than 10 per cent of clinical psychology contacts are with older people (DOH), reflecting historical imbalances in resource allocation, under diagnosis and under treatment. The recent Workforce Survey of Applied Psychologists conducted jointly by the British Psychological Society and the Department of Health showed no proportionate growth in services to older people over the last decade.

The NSF for Older People (for England) emphasised the need to root out ageist practice across health and social care to ensure that older people get access to both general services as well as specialist services for older people. Therefore, psychologists in most specialisms can expect to have contact with older people as part of their normal clinical practise and need to have an adequate understanding of this population as well as the clinical skills to address their needs. Contact can occur in Primary Care as directly referred clients of the service; in Adult Mental Health as clients, parents, and/or carers; Child and Adolescent Mental Health as grandparents or carers; in Learning Disabilities as clients and parents/carers and in Physical Health as clients and/or carers. This will also be the case for all specialist areas of work (such as forensic and substance misuse) when age boundaries are eliminated.

PSIGE, therefore, believes that to provide effective services, generic Clinical Psychology training should equip all Clinical Psychologists with the basic capability to meet the fundamental psychological needs of older people, including knowing when to refer on to specialist older adult services. In addition, the training experience needs to encourage, both in the general ethos and through specific aspects of the course, sufficient trainees to specialise in Older People's services post qualification.

1.1 The National Service Framework for Older People and the Older People's Skills and Competencies Framework

The most relevant current national policy frameworks are the National Service Framework for Older People (England) (which laid down the main priorities for services for this client group) and the developing Older People's Skills and Competency Framework. The recently published report, 'Everybody's Business' (DoH, 2005), identifies key areas of policy development for Older People's Mental Health Services. A summary of the NSF for Older People is given in Appendix 1. It is recognised that the NSF applies only to England, but this is suggested as a widely accepted framework with equal relevance to the rest of the United Kingdom.

Broadly the competencies identified within these documents require that all health providers, including psychologists:

- Are able to recognise and address discriminatory attitudes and practices.
- Are able to assess the needs and preferences of individual older people.
- Are aware of and can integrate factors to do with physical ill health, sensory impairment, disability and experience of health services into their routine practice.
- Are able to assess and intervene at the appropriate level with the main mental health problems occurring in older people.
- Have the knowledge and ability to promote healthy lifestyles in later life.

2. BPS Accreditation Criteria for Training Programmes in Clinical Psychology

The current Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology specify that:

Programmes should refer to the minimum standards which are identified and revised from time to time by the Division of Clinical Psychology's Faculties and Special Interest Groups for guidance in relation to the expected capabilities which a trainee should gain to fit them for work with specific populations and groups (Section A6).

The national standards as set out by the Division of Clinical Psychology's Faculties and Special Interest Groups (see Section B.2.5) will provide the reference information for the minimum supervised practice commensurate with competence in an area of work (Section 7.2)

The development of the syllabus should be informed by consultation with DCP Faculties and Special Interest Groups (Section 9.1).

The following points are of particular relevance to work with Older People:

Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the NHS. These requirements will be shaped in part by National Service Frameworks and national policies (Section B.2.5)

A fundamental principle is that trainees must work with clients across the lifespan, such that they see a range of clients whose difficulties are representative of problems across all stages of development (Section B.2.6.1)

While it is appropriate that Programmes should differ in their emphases and orientations, they must all provide academic teaching relevant to the full range of client groups and a wide range of clinical methods and approaches. This will include teaching on children, people with learning disabilities and older people (Section 9.2)

3. Required competencies, experiences and service settings

In order to assist in the implementation of the revised criteria, PSIGE has developed minimum standards to enable training programmes to provide trainees with the expected capabilities to fit them for work with older people.

Although these are listed individually for the sake of clarity, effective work with older people depends upon their effective integration. This can be learned and demonstrated in a number of ways including supervised practice, exercises and simulations, and academic work. PSIGE recognises that different courses will approach this in different ways and wishes to support the development and evaluation of new ways of demonstrating and evaluating capabilities.

Recommendation 1: *All trainees should have demonstrated the capabilities in Table 1 by the end of training.*

Table 1: Expected areas of capability for newly-qualified Clinical Psychologists.

Capability		NSF Standard	Accreditation Standard
1	Personal and professional recognition and understanding of how to address age discrimination	1	B1.1.6 B1.2.4
2	Able to recognise and manage the effects of differences in age between Psychologist and older people particularly in the implementation of psychological therapies	1	B1.1.2 B1.2.2
3	Able to encourage and support older people, their carers, and staff to increase autonomy, choice, and psychological well-being. Able to effectively work to increase motivation when it is low.	1	B1.1
4	Able to recognise and minimise psychological barriers to older people' independence.	2	
5	Able to demonstrate cultural sensitivity, and address culture specific expectations of ageing.	2	B1.1.2
6	Able to effectively communicate with older people. Able to overcome cognitive and sensory impairments to enable effective work to take place. Able to provide written information in the right format for an individual older person.	2	B1.1.1
7	Able to determine psychological formulations for older people with complex, multiple problems. For example, clients with co-existing dementia, depression, social isolation, substance abuse, and poverty.	2–7	B1.1.1 B1.2.1 B1.2.3
8	Able to effectively intervene, both directly and indirectly, to improve the lives of older people, and their carers, using psychological understanding and techniques based on a scientist-practitioner and reflective-practitioner model.	2	B1.1.1 B1.1.4 B1.2.3
9	Able to recognise and manage risk in older people.	2-7	
10	Have a basic knowledge of the range of services and agencies available for older people and how to access them.	3	B1.1.3
11	Able to work effectively with other providers of services for older people to address psychological aspects of health and health care.	3	B1.1.3 B1.1.4
12	Able to recognise and manage boundary issues when working with older people in different settings, e.g. patients' homes, medical wards.	2–4	B1.2.4

4. Mechanisms for achieving these competencies

All clinical psychology training courses should aim to ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 Academic Teaching

Recommendation 2: *It is important for teaching and other academic components of the Programme to provide a coherent body of knowledge relating to the needs of older people together with the skills needed for finding, evaluating, and applying this knowledge.*

Not all of this teaching needs to be within a single older persons' module, but when teaching is dispersed, care must be taken to demonstrate that trainees have been able to integrate the different topics. Similarities with and differences from other areas of work should be clear. As with supervised experience, transfer of knowledge from other areas needs to be explicit within training documents and demonstrated by trainees

Recommendation 3: *Trainees will have exposure to positive theories of age and ageing and explore ageist stereotypes and assumptions.*

Trainees will receive teaching in the majority of the following areas:

3a. *Models of individuality and personhood that recognise the diversity of older people and the heterogeneity of their needs.*

3b. *A life-span developmental perspective that recognises the importance of cohort and longitudinal effects, and includes gerontological theories of adjustment in later life, and the developmental tasks and roles of later life.*

3c. *Present and likely future individual experiences of old age; physical, social, psychological, spiritual, cultural, and sexual.*

3d. *Effects of ageing on cognitive function including "normal" or successful ageing and dementia and related conditions. This should include an understanding of the psychometric properties of assessments when used with older people.*

3e. *Understanding of legal, moral, and ethical issues, e.g. capacity, powers of attorney, protection and over-protection, do not resuscitate orders, euthanasia, choice, and consent, and their relationships to duties of care (e.g. Bournewood guidance).*

3f. *Models of healthy living and healthy communities, and interventions to promote good physical and mental health in older people.*

3g. *Models and techniques for older people's involvement in service planning and delivery.*

3h. *National policy frameworks (NSF) and other significant policy documents, e.g. Forget Me Not and the development of services within these.*

3i. *The social context of older people and current social policy e.g. Better Government for Older People, and financial benefits and pensions.*

3j. *Care frameworks and pathways including statutory, voluntary, and independent providers.*

***3k.** Roles of other professions who work with older people.*

***3l.** Abuse of vulnerable older people.*

***3m.** Common problems of old age related to bereavement, different types of dementia, late-life depression, stroke, and physical health problems This should include current NSF target areas: for example falls and fear of falling, continence, pain, disability and quality of life, and end of life issues and palliative care.*

***3n.** Models of psychological interventions for the common problems of older people at the individual, family, and systems level with the evidence base for their effectiveness.*

***3o.** Suitable outcome measures including quality of life, independence, and symptom report measures.*

***3p.** Essential psychological components of the medical care of older people.*

***3q.** Preventative interventions for the common problems of later life.*

***3r.** Pharmacology and older people including use and abuse of prescription and illicit drugs.*

PSIGE has developed a recommended curriculum for OP teaching (Appendix 2)

4.2 Clinical Placements

Supervised practice in work with older people has three functions: firstly, to enable the development of fundamental clinical skills and knowledge with wide applicability across all client groups; secondly, the provision of specific experiences in older people's work, particularly those where a number of capabilities have to be integrated; and thirdly the direct assessment of clinical competencies in these areas.

***Recommendation 4:** Specific clinical experiences should be gained, at least in part, in a specialised Older Persons' service under the supervision of a Clinical Psychologist who specialises in work with older people.*

***Recommendation 5:** Sufficient time should be spent within a specialist service for older people to allow the inter-disciplinary and inter-agency aspects of work to be understood.*

If this is not achievable, particular care will be needed, on the part of the Training Programme, to ensure that the trainee is able to integrate his or her experiences with older people in to a coherent whole; for example through seminars, case discussions or clinical or academic teaching. Joint working between Older Adult supervisors and supervisors from other specialties may be beneficial. A number of unintegrated disparate experiences with older people in order to tick off a number of discrete competencies with older adults are unlikely to be adequate.

Supervised practice should be arranged to allow trainees to gain and demonstrate the capabilities identified above. Though some of these may be transferable from other settings or client groups, they cannot be assumed to have been transferred without evidence. PSIGE recognises that means of evaluating transferable skills need to be developed, and wishes to contribute to this process.

Not all placements can guarantee all experiences and for some trainees minimum supervised practice will be over a series of placements.

Recommendation 6: *Trainees should have, within their placement experience, opportunities to reflect on the personal effects of working with older adults, especially in relation to feelings about ageing; including successful, robust aging as well as dependency, chronic ill health, loss and mortality, in order to develop the personal awareness required to address the individual client's needs.*

Recommendation 7: *Trainees' supervised experience should include the majority of the following:*

7a. *Substantive experience with a number of older people (an indicative number would be around eight or more) to ensure that appropriate clinical expertise in assessment and interventions is developed for the main presenting problems. This would usually include contact with at least one person with stroke, dementia, depression, a late life event (e.g. bereavement, terminal illness, or retirement), poor physical health, substance abuse or drug dependency, and complex problems (the co-existence of at least 3 of the above). This experience might occur on adult mental health, primary care or elective placements, or in work with families/carers. Experiences should reflect the age span within this group, i.e. people in their 7th, 8th, and 9th decades of life.*

7b. *A number of these cases should include neuropsychological and other psychometric assessments of intellectual function.*

7c. *A number of these cases should include direct interventions using recognised psychological models; for example reminiscence therapy or cognitive, behavioural, or psychodynamic therapies.*

7d. *A number of these cases should involve indirect interventions. They should include at least one with joint working with a non-NHS agency.*

7e. *At least one case should involve contact with family members*

7f. *At least one older person should be seen at home.*

7g. *At least one older person should be seen in a long-term care setting: for example, a nursing or residential home.*

7h. *At least one person should be seen in a ward, day hospital, or other NHS setting.*

7i. *A number of interventions should be evaluated using formal measures such as questionnaires or observational scales.*

7j. *There should be participation in service or practice developments that reflect the integration of psychological models into service delivery.*

7k.*There should be sufficient involvement with users and carers to grasp their personal experiences within the service system.*

4.3. Research

PSIGE welcomes and supports research that relates to the needs of older people.

The timing of older adult teaching and placements can influence the choice of trainees' small and large scale research projects. If projects have to be chosen before trainees have contact with older people, this may bias trainees against this area.

PSIGE feels that it is the responsibility of courses to ensure that the range of research is adequately reflected in the research teaching, and would be willing to assist in any developments that support this.

Recommendation 8: *Courses should ensure that trainees are aware of the potential of research in areas that relate to older people and are supported at all stages of the course in carrying out research in the specialty.*

4.4. Supervision

Supervisors need to be sensitive to the particular issues that may distinguish work with older people. Supervisors will need to be aware of, anticipate and, if needed, address the above issues at the beginning of the placement.

These issues may include:

Emotional factors

Trainees may experience high levels of anxiety about working with older people, especially if they have little prior experience with older people either in work or within their families. They may come to the placement with negative assumptions, fears about death and mortality and assumptions about clients' capacity for change.

Trainees are going to be exposed to ill health and at times death; this may trigger their own fears about their own future, mortality, and that of their parents.

Trainees may experience therapeutic impotence when faced with the reality of some people's lives.

Complexity

There can be a complexity of the client presentation – encompassing physical, mental, and cognitive difficulties.

There is a complexity to the service context, with clients involved in primary and secondary care within both specialist mental health, general medicine, social services, voluntary agencies.

Supervisors may need to support assessment and formulation and intervention planning to take account of these factors.

Models and theories

Supervisors may need to draw on a wide range of models drawn from neuropsychological, psychological, social construction, and health psychology.

It is especially important that supervisors are aware of the role of physical health problems (such as cardiac problems) and the possibility of early cognitive difficulties in their approach to assessment and formulation.

Therapeutic interventions

The evidence base for psychological interventions with older people demonstrates both the effectiveness of interventions and also the need for adaptations of techniques. Trainees may feel deskilled when faced with the need to modify their approach and question their own competence or the possibility of change. Supervisors may need to sensitively address this concern in order to give confidence and help the trainee to develop a broader therapeutic style.

Systemic issues

Many older people are referred from within a specific service setting and very many have carers involved in their lives. Systemic issues are likely to be raised within the placement experience. This requires the supervisor to help the trainee incorporate the right balance of systemic aspects and the individual client's needs for therapy. The placement may raise issues of abuse of vulnerable adults; it may also require discussion about power issues within relationships and services, and the responsibility of psychologists to challenge some of these.

Advanced generic supervisor training will address many of the issues that relate to older people's placements. PSIGE feels that there are some features of the older person's placement experience that justify being addressed in their own right. PSIGE is also aware that supervisors who do not work primarily with older people may be interested in some support in extending their supervisory skills with this client group.

Recommendation 9: *PSIGE has piloted a national supervisor workshop in this field in the autumn of 2005 which could develop as a model training module for supervisors for older people's placements and would recommend that this might be taken up by individual courses, if successful.*

4.5. Continuing Professional Development

PSIGE recognises that basic Clinical Psychology training cannot fully equip Trainees with all of the skills and knowledge necessary for successful work with older people. A systematic programme of continuing professional development under the supervision of a Consultant Clinical Psychologist who specialises in work with older adults will be needed to fully equip qualified staff for independent practice.

Review Process

PSIGE recognises that full implementation of these standards will be a challenge for some Training Programmes.

PSIGE will work in partnership with other specialties and Training Programmes to develop ways of flexibly training Clinical Psychologists to have the minimum capabilities identified in this document. There are many examples of existing good practice which PSIGE plans to disseminate nationally, in conjunction with training courses.

Specific areas of work that PSIGE would like to develop further are tools for auditing trainee experiences, methods for supporting supervisors in other specialties who are providing experiences with older people and ways of assessing transferable competencies.

These guidelines will be reviewed in 2009. At that point, if not earlier, CPD requirements should also be considered, including the type of competencies and experiences that should be consolidated in the first 18 months post-qualification.

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Appendix 1 – The National Framework for Older People (England)

The NSF for Older People specifies eight aims for Older Peoples' services:

1. To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age

2. To ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

3. To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

4. To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

5. To reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services.

6. To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

7. To promote good mental health in older people and to treat and support those older people with dementia and depression.

8. To extend the healthy life expectancy of older people

Appendix 2 – Model curriculum

Working with Older People: Outline syllabus for the academic component of the Doctorate in Clinical Psychology

Prepared by Linda Clare & Jan Oyebode for the PSIGE national sub-committee on clinical training – 20 January 2004

Introduction

This document presents aims, objectives, and an outline syllabus for the teaching on work with older people offered as part of the academic component of the doctorate in clinical psychology. Members of the PSIGE national sub-committee for Clinical Psychology training have prepared this outline. It is intended as a resource for PSIGE members, for directors and staff of clinical psychology training courses, and for clinical psychology trainees. It does not set out to prescribe what must be taught, but offers an overview of what a good Course might aim to include, either as a designated module on working with older people or integrated into the later life aspects of a generically organised curriculum.

PSIGE recommends that 'teaching and other academic components of the Training programme must provide a coherent body of knowledge relating to the needs of older people together with the skills needed for finding, evaluating, and applying this knowledge. Not all of this should be within a single module, but when teaching is dispersed, care must be taken to demonstrate that trainees have been able to integrate the different topics. Similarities with and differences from other areas of work should be clear. As with supervised experience, transfer of knowledge from other areas needs to be explicit within training documents and demonstrated by trainees.'

Aims and objectives of academic teaching on work with older people

Aims

1. To ensure that trainees have an awareness of common attitudes to ageing and to older people.
2. To develop an understanding of the professional, clinical and organisational issues pertinent to the care of older people, including themes of continuity and difference from younger adults.
3. To educate trainees about physical and psychological conditions more commonly associated with later life.
4. To develop clinical assessment and treatment skills necessary for working with older people, incorporating an awareness of cultural, age and cohort issues.
5. To provide trainees with enough information about common problems and themes, and ways of responding to these, for trainees to feel prepared for their work on placement with older adults, and enough guidance for trainees to know where to look for more in-depth information.
6. To enable trainees to identify where skills and knowledge they have gained in other areas of work are relevant to working with older people, and where they need to acquire different skills or develop existing skills further in order to work effectively with older people.
7. To stimulate enthusiasm for working with older people and encourage trainees to continue their involvement in this area.

Learning Objectives

On completion of their academic teaching trainees should be able to:

1. Describe the characteristics of older cohorts in terms of their life experiences, and physical, social, cultural and historical contexts, and conceptualise the challenges and experiences of later life using a lifespan developmental framework.
2. Be aware of factors that contribute to 'successful ageing' and well-being in later life.
3. Recognise ageism and its influence on society and professionals, including themselves.
4. Demonstrate knowledge of the dementias, including presenting symptoms, patterns of change in neuropsychological profiles, key assessment tools and effects on the individual and their family
5. Describe the characteristics of issues that are of particular relevance to psychological well-being in later life, including adjustment to dementia, bereavement and loss, sensory impairment, physical illness including stroke, and facing death.
6. Demonstrate knowledge of how longstanding mental health problems may manifest in later life.
7. Demonstrate awareness of the impact of common clinical issues for the older person, their family and any service providers.
8. Demonstrate an up-to-date knowledge of psychological theory in relation to the assessment of older people, taking into account the multiplicity and complexity of problems and risk factors that may present.
9. Demonstrate an up-to-date knowledge of approaches to formulation and therapeutic intervention with older adults, including both specific approaches, and how to adapt more standard interventions for use with older people.
10. Demonstrate knowledge of specific interventions for people with dementia and their families.
11. Be aware of systemic issues in relation to working with older adults' families and care systems.

Suggested syllabus content

1 General issues in ageing

- Attitudes and expectations to working with older people
- Relevant social history and demographic information
- Ageist stereotypes; ageism and its consequences
- The social context of older people; retirement issues including loss of social role, diminishing social networks; isolation and geographically distributed families, current social policy, including financial benefits and pensions.
- Discrimination and health provision
- Elder abuse
- Understanding of legal, moral, and ethical issues in relation to vulnerable older people, e.g. capacity, powers of attorney, protection and over-protection, do not resuscitate orders, euthanasia, consent to treatment, advance directives, Mental Health Act, and the relationship of these to duty of care
- Caregiving
- Diversity and heterogeneity among older people, and the effects of culture, ethnicity, gender and sexual orientation in relation to ageing
- Present and likely future individual experiences of old age, including physical, social, psychological, spiritual, cultural, and sexual aspects

2 Normal ageing and the impact of life events

- A life-span developmental perspective
- Gerontological theories of adjustment in later life; adaptation; successful ageing; models of healthy living and healthy communities
- Developmental tasks and roles of later life; typical life experiences
- Social changes with ageing
- Effects of ageing on cognitive function
- Effects of ageing on physical and sensory functioning
- Bereavement, death and dying
- Understanding the limitations of knowledge about ageing: methodological (e.g. cohort versus longitudinal studies); conceptual (e.g. 'intelligence' as in WAIS being related to younger people's lives); and data related (e.g. lack of age-related norms).

3 Physical and psychological disorders in older people

- Models of psychological formulation (such as Knight's maturity-specific challenge model) for helping to understand the common problems of older people including the influence of individual, family, and systems factors
- Interventions for the common problems of older people at the individual, family, and systems level with the evidence base for their effectiveness
- Preventative interventions for the common problems of later life
- Use of suitable outcome measures including quality of life, independence, and symptom report measures

3.1 Understanding dementia and related disorders

- Theoretical frameworks for understanding dementia, including medical models, Kitwood's dialectical model, social constructionist models, and biopsychosocial models
- Implications of these models for assessment and intervention.
- The subjective experience of dementia; models of adjustment and coping; awareness and denial
- The experience and needs of family caregivers of people with dementia; challenges and positive aspects of caregiving.

3.2 Presentation of dementia and related disorders

- Different types of dementia
- Differential diagnosis
- Prevalence
- Psychological and behavioural changes in dementia
- Impact of life events in dementia
- Impact of malignant social psychology
- Quality of life

3.3 Assessment of people with dementia and related disorders

- Good practice in pre-assessment counselling
- Neuropsychological assessment
- Psychological and functional assessment
- Good practice in telling the client the outcome of assessment
- Knowledge of current pharmacological treatments

3.4 Psychological problems in later life

- Presentation of depression in older people; prevalence; risk factors; prognosis; treatments and their outcome, especially psychological treatments.
- Late-onset versus earlier-onset depression
- Anxiety
- Psychosis with onset in later life

- Impact of earlier traumatic events in later life
- Continuation or recurrence of long-standing mental health problems
- Substance abuse and alcohol
- Complex reactions to bereavement
- Suicide and attempted suicide

3.5 Physical health in old age

- Aspects of physical well-being (e.g. sleep, sex).
- Life expectancy and active life expectancy; concept of reserve capacity; relationship between impairment, disability and handicap; disability and quality of life; rehabilitation; obstacles to recovery from illness; consent to treatment.
- Essential psychological components of the medical care of older people
- Physical problems more commonly associated with later life, including stroke.
- Falls prevention and fear of falling
- Continence
- Pain
- End of life issues and palliative care
- Pharmacology and older people including use, addiction to and abuse of prescription and illicit drugs
- Co-morbidity and interaction of physical and psychological problems

4 Service provision

- How services for older people have developed; national policy frameworks and other significant policy documents; care frameworks and pathways including statutory, voluntary, and independent providers; day care and residential services
- Recent legislation and directives as they relate to work with older people
- Multi-disciplinary and inter-agency working
- Roles of other professionals who work with older people.
- Memory clinics and their implications for assessment and intervention in dementia
- Community psychology approaches and older people
- Models and techniques for older adult involvement in service planning and delivery

5 Intervention approaches and clinical skills development

The development of clinical skills in a number of areas, including as many as possible of the following:

5.1 Interventions in the early stages of dementia

- Support groups for people with dementia
- Cognitive rehabilitation
- Psychological therapies
- Reminiscence and life review
- Work with couples and families where one member has a diagnosis of dementia
- Training and support for carers
- Knowledge of current pharmacological treatments

5.2 Interventions in the later stages of dementia

- Person-centred care
- Working in continuing care environments
- Approaches aimed at improving quality of care; dementia care mapping
- Cognitive stimulation (reality orientation)
- Validation approaches

- Working with difficult or challenging behaviours
- Adapting the environment
- Supporting family caregivers
- Working with care staff

5.3 Rehabilitation

- Neuropsychological/cognitive rehabilitation
- Psychological contributions to physical rehabilitation for older people (e.g. post-stroke, or with conditions such as Parkinson’s disease)

5.4 Cognitive-behavioural approaches

- Cognitive-behavioural approaches for depression and for anxiety
- Interventions for fear of falling and the psychological contribution to falls groups
- Interventions for older people with psychosis

5.5 Other psychological therapies and approaches

- Psychodynamic approaches; working with transference and counter transference; CAT
- Interpersonal therapy
- Narrative approaches
- Solution-focused approaches
- Working with traumatic experience
- Family therapy with older people
- Working systemically with care staff
- Interventions for elder abuse
- Community psychology (including working with voluntary agencies)
- Subtleties of multidisciplinary and team work

Appendix 3 – Members of the PSIGE Training Committee who developed guidelines

Cathy Amor (until October 2002), Senior Clinical Tutor, Lancaster Clinical Psychology Training Scheme, Lancaster University.

Cath Burley, The Bungalow, Gables Drive, Peterborough District Hospital, Peterborough.

Steve Boddington, Consultant Clinical Psychologist, Southwark MHOA Psychology Service, Maudsley Hospital, London.

Linda Clare (until Summer 2003), Lecturer in Clinical Psychology, Sub-department of Clinical Health Psychology, University College, London and Consultant Clinical Psychologist, Camden and Islington Mental Health and Social Care NHS Trust, now Senior Lecturer, School of Psychology, University of Wales, Bangor.

Daniel Collerton, Consultant Clinical Psychologist, South of Tyne and Wearside Mental Health NHS Trust, and Honorary Teacher in Clinical Psychology, University of Newcastle-upon-Tyne.

Susan Conaghan, Clinical Psychologist, Glenkirk Centre, Glasgow.

Steve Davies, Joint Course Director, Hertfordshire Course.

Sylvia Dillon, The Whelan Building, Quadrangle, Brownlow Hill,
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Catherine Dooley (convenor 2003 -), Consultant Clinical Psychologist,
South West London and St. George's Mental Health NHS Trust,
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Carolien Lamers, North Wales Clinical Psychology Programme,
School of Psychology, University of Wales, Bangor, Gwynedd.

Tina Lee, Clinical and Academic Tutor, CASPD, Salomons, Southborough Tunbridge Wells, Kent.

Jan Oyebode (convener until summer 2003), Senior Lecturer and Course Director, University of Birmingham.

Alistair Smith, Consultant Clinical Psychologist, Central Lancashire Psychological Services for Older People, Lancashire Care NHS Trust.

Bob Woods, Professor of Clinical Psychology of Older People, Dementia Services Development Centre, Wales.

Appendix 4 – Consultation on initial draft

The draft was circulated for comments in February 2003 to:
All PSIGE geographical groups;
Chairs of GTiCP, CTCP, MPTB, DCP;
Chairs of DCP Faculties and Special Interest Groups;
Directors of Clinical Psychology Training Programmes (via GTiCP).

By mid September 2003, replies had been received from:
All PSIGE geographical groups;
Faculty of Addictions;
Directors of seven Training Programmes.

The draft was then revised to take account of new DCP requirements on the content of guidance documents and was circulated for comments to:
All PSIGE geographical groups.

The British Psychological Society was founded in 1901 and incorporated by Royal Charter in 1965. Its principle object is to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge.

The Society has more than 42,000 members and:

- has branches in England, Northern Ireland, Scotland and Wales;
- accredits nearly 800 undergraduate degrees;
- accredits nearly 150 postgraduate professional training courses;
- confers Fellowships for distinguished achievements;
- confers Chartered Status for professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 10 scientific journals and also jointly publishes *Evidence Based Mental Health* with the British Medical Association and the Royal College of Psychiatrists;
- publishes books in partnership with Blackwells;
- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through the *Appointments Memorandum* and *www.appmemo.co.uk*;
- provides a free 'Research Digest' by e-mail;
- publishes newsletters for its constituent groups;
- maintains a website *(www.bps.org.uk)*;
- has international links with psychological societies and associations throughout the world;
- provides a service for the news media and the public;
- has an Ethics Committee and provides service to the Professional Conduct Board;
- maintains a Register of more than 12,000 Chartered Psychologists;
- prepares policy statements and responses to government consultations;
- holds conferences, workshops, continuing professional development and training events;
- recognises distinguished contributions to psychological science and practice through individual awards and honours;
- maintains a Register of Psychologists Specialising in Psychotherapy.

The Society continues to work to enhance:

- recruitment – the target is 50,000 members by 2006;
- services – the Society has offices in England, Northern Ireland, Scotland and Wales;
- public understanding of psychology – addressed by regular media activity and outreach events;
- influence on public policy – through the work of its Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership.

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SECTION 8, APPENDIX 5

DATA PROTECTION AND ENCRYPTION: PRESERVING CLIENT CONFIDENTIALITY WHEN USING COMPUTERS

This appendix sets out Course policy on the use of password protection and encryption and identifies mandatory rather than voluntary advice: trainees will be expected to follow the guidance scrupulously. It also includes advice on the procedure for encrypting sensitive files.

The reason for protecting data is to ensure that information about clients remains confidential, and this should be a primary concern for all clinicians. The consequences of losing unencrypted client data are potentially grave, and it is very much in trainee's professional interests to follow the procedures described below.

Background

As part of their training trainees will have information about clients on their computers, and from time-to-time will transfer potentially sensitive information from one computer to another, or from a digital device to a computer. Examples of sensitive material include written material (such as case reports, some service-related reports or supervision notes) as well as digital audio or video recordings.

Research data can also contain client-sensitive information, and will usually fall into the orbit of the procedures described below.

Although this document identifies ways of managing some obvious risks to confidentiality we cannot anticipate all eventualities. The important thing is to hold in mind that preserving client confidentiality is paramount, and all your actions should reflect this ethical principle. Trainees should consult their placement supervisors and course tutors to ensure that they are not inadvertently risking breaches of confidentiality in the way they transport or store data.

In what follows the scenario to keep in mind is not only whether hardware is stolen, but also whether non-authorised individuals could gain access to computers or digital devices through the web.

Recording and storage of confidential client information

All Trusts will have policies regarding the ways in which information about clients is recorded and stored, and the conditions under which it can be transported. Trainees should consult with supervisors at the start of each placement in order to identify relevant Trust policies, and hence ensure that their actions are compliant with these. Policies will vary in their details from Trust to Trust, so it is important for trainees not make assumptions about local procedures.

Computers and memory sticks

Because they are undertaking an educational programme trainees will hold client-related information on their computers – case reports being an obvious example. It is important that any computer used by a trainee to hold such information is:

a) accessible only by the trainee, and not by multiple users
b) that the computer is password protected
c) that any sensitive files are encrypted using the encryption programme recommended by the course (see the end of this document for details)

Because memory sticks are especially vulnerable to being lost it is critical that any confidential material they contain is encrypted. The encryption programme recommended by the course enables trainees to encrypt and decrypt material in order to transport it between computers.

In some settings trainees will only be able to use encrypted memory sticks supplied by the Trust. As above, trainees should establish local policy before making use of their own memory sticks.

Digital recording devices

As above any recordings need to be encrypted. Because this is not usually possible via the device itself, recordings should never be stored on the recorder, but should be transferred to a memory stick and encrypted, and the original recording removed from the device itself.

Retention of recordings

Recordings are made with a purpose in mind, and should only be retained for as long as they fulfil that purpose. This means that they should be deleted when no longer required, and usually at the end of the placement. However, some course requirements include submission of session recordings (for example, transcript-based case reports or the the clinical viva). This means that recordings should be retained until it is clear that they will not be requested as part of an assessment for educational purposes.

How to encrypt files

Basic advice about data storage and encryption can be found here:

www.ucl.ac.uk/isd/common/cst/good_practice/encrypt/encrypt/GuidanceStorageSensitiveData

Information about 7-zip (the recommended programme for UCL users) can be found here:

www.ucl.ac.uk/isd/staff/ads/help/guides/encryption

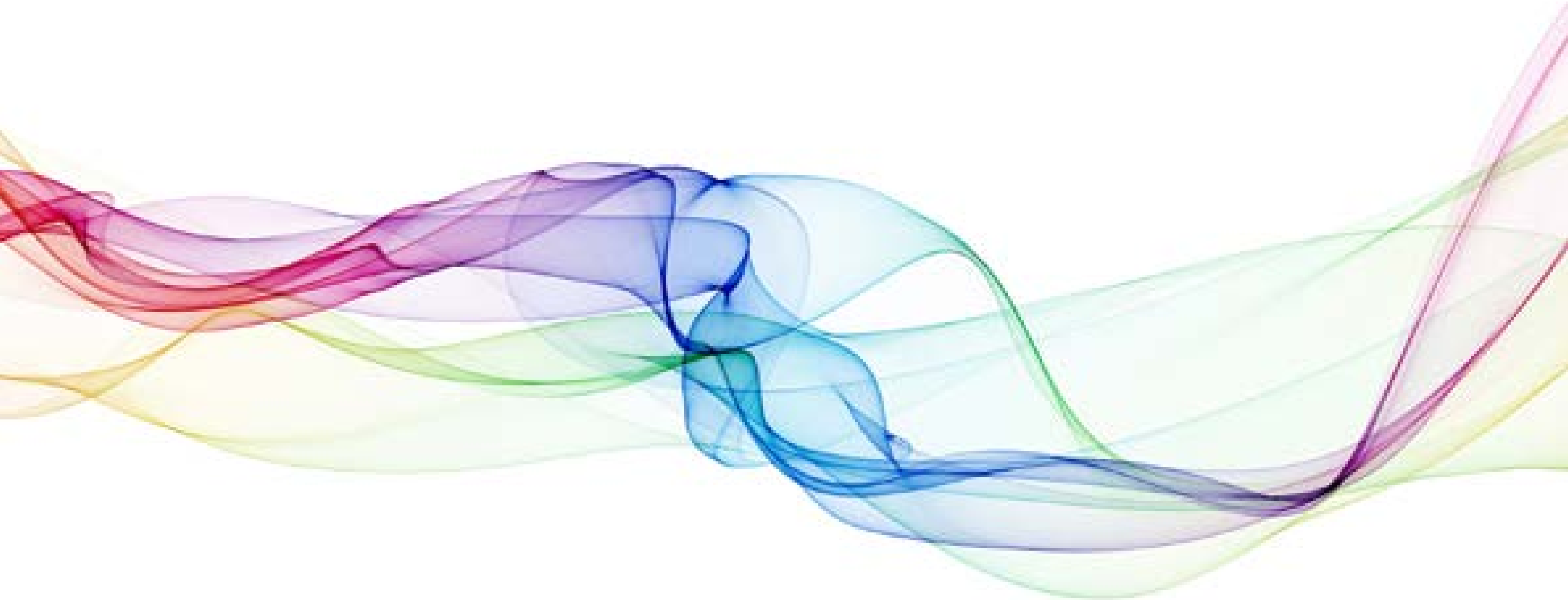
or alternatively downloaded from here:

www.7-zip.org/

The British
Psychological Society
Promoting excellence in psychology

Practice Guidelines

Third edition



August 2017

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Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

Contents

Preface

This Third Edition of the Practice Guidelines replaces the second edition published in 2009. Legislation, practice and technology have moved on since then and these changes are captured in the new guidance.

This edition of the guidelines was produced through the British Psychological Society's Professional Practice Board by a working group drawn from the range of Member Networks across The Society whose members are engaged in professional practice, as well as representatives from relevant expert reference groups of The Society, in particular areas of practice. Further information is available in ***Appendix 3: How this document has been developed.***

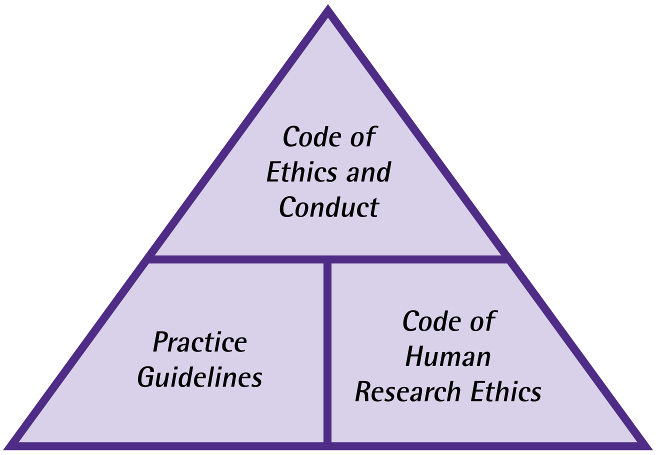
These Practice Guidelines aim to define good practice for all psychologists whether registered, chartered or in training and offer guidance for decision making. The Guidelines have been designed for broad application across the full range of applied psychology.

The first part of the guidance (sections 1–3) set out considerations for psychologists on different contexts of practice. The second part of the guidance (sections 4–8) sets out guidance for psychologists on how to manage work with clients.

It is recognised that in addition psychologists may require more detailed guidance for some particular roles and responsibilities or for particular situations in which they work. Further information is available in the ***Appendices***.

The Society expects that the guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others and the specific circumstances. No guidance can replace the need for psychologists to use their own professional judgement. Effective practice means exercising this professional judgement in a defensible way that does not put clients or the public at risk, or undermine, or call into question the reputation of the profession as a whole.

The Guidelines will be reviewed in accordance with Society policy within a maximum period of five years in order to reflect current legislation, evidence and practice contexts. Psychologists using the Practice Guidelines should do so in conjunction with the ***BPS Code of Ethics and Conduct*** and the ***BPS Code of Human Research Ethics***, as necessary.



Glossary of terms

Client

The Society's *Code of Ethics and Conduct* uses the term person or people throughout, this is in recognition of the fact that the document is generic and may be used by all psychologists; academics, researchers, students and practitioners alike.

Throughout this Practice Guidelines document the term 'client' is used and refers to any person or persons with whom a psychologist interacts on a professional basis.

For example, the 'client' may be a couple, a family group, an educational institution, a community organisation or group or a private or public organisation including a court, an individual (sometimes referred to as, for example, athlete, child/young person, patient, prisoner, coachee, service user, stakeholder, leader, or student), who are in receipt of the services of the psychologist.

Psychologist

Throughout this Practice Guidelines document the term 'psychologist' is used and refers to all psychologists whether registered, chartered or in training who provide psychological services across the full range of applied psychology, in any context of practice.

1. How psychologists work

1.1 Legal and professional obligations of psychologists

Psychologists' professional practice is impacted upon and governed by a range of legislation and regulation. Particular psychological disciplines may also need to consider additional legislation, regulation and guidelines. It is the psychologist's responsibility to ensure they are aware of the legislation and guidelines that govern their particular area of practice as well as the terms of their employment or terms contracted with a commissioner of their services.

Psychologists are also advised to consider membership of a union or similar body to ensure they have access to appropriate representation, support and legal advice should they be subject to a complaint or disciplinary action, or require support for example with an employment grievance, which may be related to concerns over quality and standards of psychological service provision.

Further information is available in the ***Appendices***. Important examples to note are:

Health and Care Professions Council (HCPC) Registration

It is a statutory requirement for all psychologists wishing to practice using one of the titles protected by the HCPC to register with the HCPC. Unregistered psychologists offering services to the public in any of the domains regulated by the HCPC may commit an offence by doing so, even if they refrain from using protected titles, provided intent to deceive can be proved. The Society's position is that it is in the interests of both the public and the profession for all psychologists providing services in a regulated domain to be registered with the HCPC.

Professional competence

Psychologists should value the continuing development and maintenance of high standards of competence in their practice and the importance of working within the recognised limits of their knowledge, skill, training, education, and experience. Psychologists should consider advances in the evidence base, the need to maintain technical and practical skills and knowledge and the limits of their competence. This is stipulated in both the ***BPS Code of Ethics and Conduct*** and the ***HCPC Standards of Proficiency***.

Professional indemnity insurance

The UK Government has introduced legislation (The Health Care and Associated Professions (Indemnity Arrangements) Order 2014) which now makes it mandatory for health professionals to have a professional indemnity arrangement in place. The HCPC has made having such an arrangement in place a condition of registration.

This may be achieved either through the employer or through a privately arranged policy. An employer's insurance may provide cover only for a negligence claim but not for the costs of a disciplinary hearing. It is the psychologist's responsibility to check carefully that they have cover in place that meets their personal/professional needs. Further information is available in the ***Society document: Career Support and Development***

Disclosure and Barring Service (DBS) Checks

Psychologists working in certain fields, for example with children or in healthcare, will need to demonstrate they have had a satisfactory criminal records check at the appropriate level for the nature of the work undertaken.

Applicants will be provided with a certificate to demonstrate this. Applicants cannot request a check personally, this can be requested by a psychologist's employer. For psychologists practising independently the Society offers this as a service to members. Further information is available on the ***Society Website: https://beta.bps.org.uk/Practice-Guidelines***

Equality Act 2010

This Act protects people against unfair treatment, promotes equality and prevents discrimination against any of nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Respect is a core ethical value for psychologists and a commitment to equality of opportunity is embedded in all aspects of psychological practice. Psychologists, where they operate in an organisational context, must also seek to encourage and influence others in ensuring that equality of opportunity is embedded in all thinking and all practice relating to access to services for client groups and recruitment and employment practices.

Providers of service to the public must also make reasonable adjustments for people who have a disability under the Act. This requirement is anticipatory so requires consideration, and adjustment where reasonable, of any barriers which may prevent a person with a disability from using a service.

Data Protection Act 1998

The Data Protection Act defines personal and sensitive personal data, and data must be processed in accordance with eight principles. It gives individuals the right to know what information is held about them and provides a framework to ensure that personal information is handled properly.

Good information governance is at the heart of safe practice. It encompasses physical data security, access controls and acceptable use, data quality, and records management, among other things. Psychologists must have appropriate security to prevent any personal data held from being accidentally or deliberately compromised. In most circumstances, independent practitioners will also need to register as a data controller with the Information Commissioner's Office.

Further information is available in ***Section 7.1: Information governance, Appendix 1: Relevant legislation*** and ***Society Document: Data Protection Act 1998 – Guidelines for Psychologists.***

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides public access to information held by public authorities. Public authorities include government departments, local authorities, the NHS, State schools and police forces.

It does this in two ways:

- public authorities are obliged to publish certain information about their activities; and
- members of the public are entitled to request information from public authorities.

The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland, and by UK-wide public authorities based in Scotland. Information held by Scottish public authorities is covered by Scotland's own Freedom of Information (Scotland) Act 2002.

This legislation permits information to be withheld from disclosure in certain prescribed circumstances, for example information provided in confidence, related to law enforcement or where it relates to personal matters.

Health and Safety at Work Act 1974

This Act places a duty on all employers 'to ensure, so far as is reasonably practicable, the health, safety and welfare at work' (Part 1, Section 2.1) of all their employees. Employees themselves also have obligations under the legislation.

Working together to safeguard children guidance

The Government website provides statutory guidance on inter-agency working to safeguard and promote the welfare of children. Statutory guidance is issued by law; it must be followed unless there is a good reason not to. All organisations, including charities, are expected to comply with this government inter-agency statutory guidance. Psychologists have a duty of care to both their clients and the public. Any allegations of abuse, either ongoing or historic, must be taken seriously and consideration must be given about breaking confidentiality especially in cases where other vulnerable people may be at risk. Further information is available in ***Section 4: Safeguarding***.

Mental Capacity Act 2005

The Mental Capacity Act (2005) provides a clear and comprehensive framework with regard to capacity and consent for all individuals aged 16 years and above in England and Wales.

There are five key principles set out in the Act which underpin practice (quoted from legislative source):

(i) A person must be assumed to have capacity unless it is established that he lacks capacity.
(ii) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
(iii) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(iv) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(v) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

In Scotland the Adults with Incapacity (Scotland) Act 2000 applies and in Northern Ireland the Mental Capacity Act (Northern Ireland) 2016 is used.

Mental Health Act 1983 as amended 2007

The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

The Act sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients. The Code of Practice[1] provides statutory guidance for mental health professionals on how they should carry out their responsibilities in practice under the MHA. Although the Act allows for people to be compulsorily detained and treated without their consent if required, empowerment and involvement of patients as far as is possible is required by the Code of Practice.

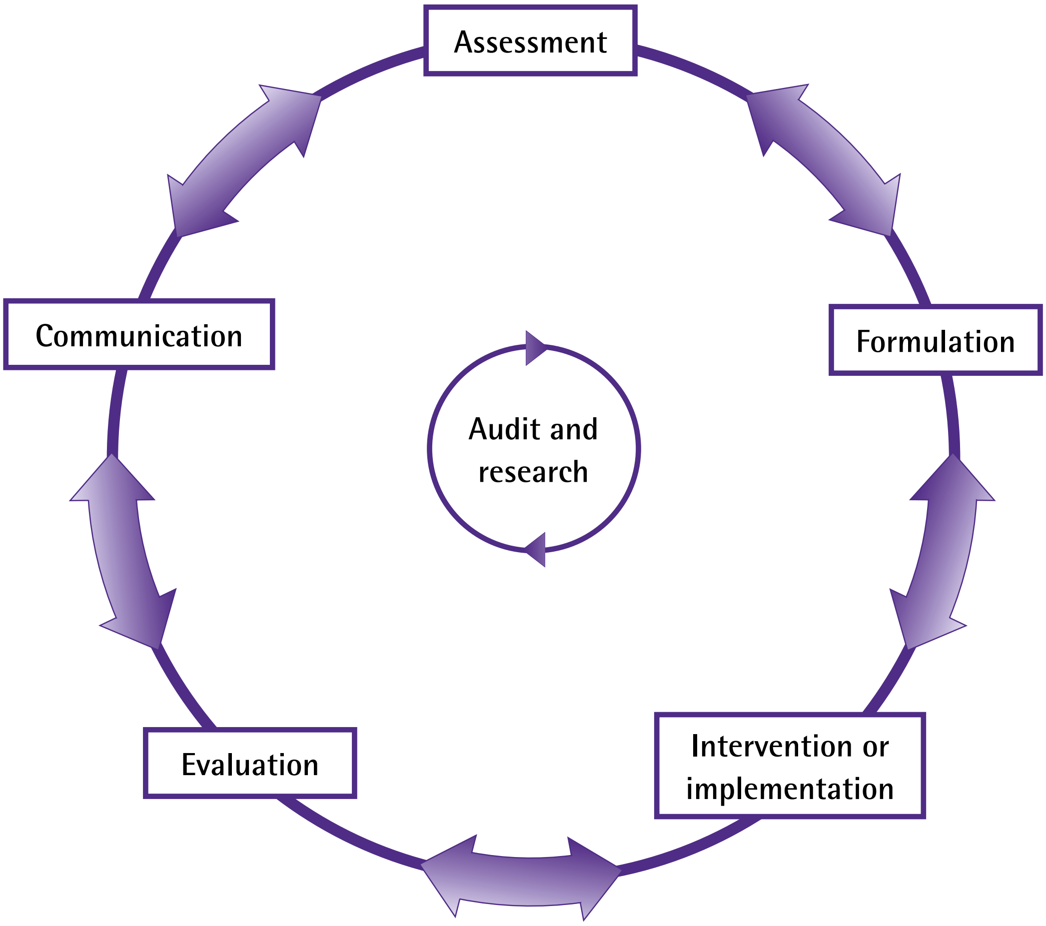
Those involved in working with people subject to provisions of the MHA, including psychologists, must understand and give consideration to the five key principles set out in the Code:
(i) least restrictive option and maximising independence;
(ii) empowerment and involvement;
(iii) respect and dignity;
(iv) purpose and effectiveness; and
(v) efficiency and equity.

1.2 Cycle of professional practice

The professional practice of psychologists is underpinned by four key ethical values – Respect, Competence, Responsibility and Integrity – and five core skills:

- **assessment** and establishment of agreements with the client;
- **formulation** of client needs and problems;
- **intervention or implementation** of solutions;
- **evaluation** of outcomes; and
- **communication** through reporting and reflecting on outcomes.

These core competencies flow and inform each other as illustrated below.



Assessment and establishment of agreements with the client

Assessment of psychological processes and behaviour is derived from the theory and practice of both academic and applied psychology. It includes both assessing change and stability, and comparison with others. Assessment procedures used will depend heavily on the practice context and may include:

- the development and use of psychometric tests following best practice;
- the application of systematic observation and measurement of behaviour in a range of contexts and settings;
- devising structured assessment strategies for individual clients, teams and organisations; and
- the use of a range of interview processes with clients, carers, other stakeholders and other professionals.

Results of these assessments are integrated within the context of the historical, dynamic and developmental processes that will have shaped the client as well as future aspirations or needs. Psychologists have the ability to assess the suitability of different measurement procedures, depending on the purpose for which the assessment is needed, as well as being competent to devise and use context-specific procedures.

Formulation of client needs and problems

Formulation is the summation and integration of the knowledge that is acquired by the assessment process. This will draw on psychological theory and research to provide a framework for describing a client's needs. Because of their particular training in the relationship of theory to practice, psychologists will be able to draw on a number of models to meet needs or support decision-making. This process provides the foundation from which actions derive. What makes this activity unique to psychologists is the knowledge base, experience and information on which they draw. The ability to access, review, critically evaluate, analyse and synthesise data and knowledge from a psychological perspective is one that is distinct to psychologists, both academic and applied.

Intervention or implementation of solutions

This will be the stage where the client's needs, as described by formulation, begin to be met. This may involve the use of psychological models or approaches to, for example, facilitate change, solve a problem or improve the quality of a relationship. All these interventions, or implementation of solutions, are tests of the provisional hypotheses contained in the formulation, and are subject to repeated modification in the light of experience and new data.

Evaluation of and reflecting on outcomes

Evaluation is used to measure the effectiveness of activities and interventions both during and after their implementation. The results of any evaluation and reflection will impact the next steps taken by a psychologist.

Although employers and others may demand certainty about outcomes, psychologists should always be careful to make it clear that they are able to provide only interpretations of behaviour, and advice and guidance, rather than necessarily predicting future behaviours.

Communication through reporting

Communication skills are integral to all aspects of a psychologist's role. Effective communication skills are essential in relation to all aspects of work with others. Communication skills include communication with clients, all forms of electronic and verbal communication, professional letters and reports, and the dissemination of research findings.

Audit and research

Audit and research underpin the cycle, as they help to inform all stages of professional practice.

Audit aims to evaluate how close assessment, formulation, intervention and implementation are against a set of previously given standards of practice. Audit also evaluates how protocols and procedures, for example related to consent or recording of activity, have been followed.

Research provides the evidence base for the practice of psychology. Research methods in psychology vary from qualitative observation to quantitative scientific method, so it is important to distinguish the nature and quality of the evidence underpinning any knowledge or techniques being applied. In general, basic research develops theories, models and data to describe and explain psychological processes and structures, while primary research develops and evaluates ways of using psychological knowledge to intervene with people, organisations, processes or technologies to achieve desired effects. Secondary research consolidates other research to identify higher order trends and directions.

1.3 Reflective practice

One of the key processes that should be encouraged for psychologists is having a complex understanding of self in the context of others. The HCPC requires reflection in the record of continued professional development in order to retain continued registration.

Psychologists will need to make decisions about clients which may have a profound impact on their lives. Decision-making is often subject to various competing biases. Psychologists should be aware of the possibility that they may be influenced by considerations which are not driven by professional knowledge, skills or experience. Maintaining awareness of these biases is important when trying to think through dilemmas.

Sources of influence and bias may include:

- **Cognitive Biases –** Over 150 have been described[2,3,4] including salience (how readily something comes to mind), confirmation bias (the human tendency to look for evidence that confirms their belief and to ignore other evidence), loss aversion (risky behaviour to avoid loss), beliefs about disclosure (tendency to be more honest when they believe their actions will be known by others), and dissonance reduction (justifying actions if consequences are considered worth it).
- **Personal Experience –** the experience of the psychologist may affect how they view or treat a client or situation. This may include current or historical trauma, or the kind of organisation and culture with which they are most familiar. Interventions which may be appropriate in one context may be ineffective and cause distress in another.
- **Motivation –** the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint.
- **Health –** psychologists should be mindful of the potential effect of health conditions or medications which they may be taking, on their practice.
- **Control over the psychologist's own practice –** this refers to clarity and openness in the management of the psychologist's business and maintaining the professional's autonomy in their interactions with clients.
- **Pro bono public work –** psychologists are encouraged, and personally motivated to

engage with such work, while being mindful of impact on the value that is placed on the profession as a whole.

- **An unethical environment** – maintaining self-recognition of what the appropriate ethical standard should be, irrespective of the prevailing situation.
- **Environment** – political realities may lead the psychologist to make compromises; while there is nothing wrong with compromises, their constant use may mean a decline in overall standards.

The literature is generally pessimistic about the ability of practitioners to overcome some of these biases, considering them to be inherent in human thinking patterns. By being aware of and acknowledging them, it can be possible to manage their influence. For example, biases can be levelled out by presenting information in different ways, by engaging the perspectives of people with different experiences and expectations, or by priming thinking with different examples.

A key factor in developing and maintaining these skills is the use of consultation or supervision and having a space where it is possible to open up thinking to the mind of another with a view to extending knowledge about the self.

It is important that psychologists from all disciplines look after their own wellbeing. This is not only important for them as individuals, but also for the quality of the care they give their clients. In their practice and, for example, within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing.

It is also important for psychologists to evaluate effectiveness of practice, by welcoming feedback from clients. This can be difficult due to fears of criticism but reflective practitioners are eager to improve and welcome any feedback that will support this process.

1.4 Continuing professional development

Continuing professional development (CPD) is the professional and work-related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence. The Society provides an online facility to record CPD, further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines***.

- CPD is both a professional expectation and an individual responsibility to taking a structured and self-managed approach to further learning through:
  – actively engaging in a range of CPD
  – maintaining a record of CPD
  – applying learning from CPD to professional practice.
- There is a range of formal and informal learning activities that may be used for CPD and it is recommended that psychologists engage in a mix of CPD activities.
- Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective, outcomes-based approach which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for clients and the services provided.

- All members who are registered with the HCPC are required to comply with their CPD requirements as a condition of continued professional registration. Further information is available in ***Appendix 2: Websites and further information***

Mentoring

Psychologists may seek a mentoring relationship with colleagues in order to focus their attention on skills to add to their competencies. Psychologists taking on the role of mentor often support the psychologist with their career path. Early career psychologists may find it beneficial to be mentored by a more experienced psychologist.

1.5 Consultation/supervision

Consultation or supervision is considered an essential part of good practice as a psychologist. There is no legal requirement for supervision, although it is considered an ethical and professional expectation to engage in appropriate consultation in order to support effective practice. Provision of this is therefore an important underpinning to good quality service delivery. The Society's position is, for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice.

The objectives of consultation/supervision are:

- to provide practitioners with consultation on their work with clients;
- to enhance the quality and competence of practice offered to all clients;
- to offer psychologists intellectual challenge enabling reflection, transformational learning and psychological support to maximise their responsibility for appropriate self-care; and
- to contribute to the CPD of both psychologist and supervisor by developing competence in the use and practise of supervision.

All aspects of practice are appropriate for discussion in supervision, including research activity, administrative and managerial work, service developments, team working, teaching and the process of supervising others. Supervision is not personal therapy and nor is it a form of, or substitute for, line management or appropriate training.

For psychologists working in a wide range of settings such as therapeutic and organisational settings, supervision is a core component of the psychologist's CPD. For some areas of practice, the nature of supervision changes over time. This may be unique to each psychologist and the context of their application. Expectations should be agreed from the outset and reviewed at appropriate intervals.

Forms of consultation/supervision

Supervision may take the form of clinical supervision, mentoring, coaching, supervision on placement/work setting, tutorials and peer support. Psychologists may engage in one to one supervision; group supervision (facilitated or non-facilitated) or peer supervision and any of these may be face to face or virtual. Whilst it should not be a substitute for line management, a psychologist's supervisor may also be their line manager.

Those working in independent practice, or in the absence of service-based supervision, should seek supervision from appropriately qualified and experienced personnel as appropriate. Peer supervision (individual or group) may be an appropriate way to find collegial support.

Psychologists may select different supervisors, depending on their preferred supervisory style, nature, orientation and their needs at the time. Particularly for experienced psychologists, this may be from an experienced colleague from outside their profession, professional specialty or organisation. Psychologists could also invite supervision from experts by experience for whom they provide services, where appropriate to the context of practice.

The Society maintains the Register of Applied Psychology Practice Supervisors (RAPPS), which recognises psychologists with special expertise in supervision and supervisory practice. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines***.

Amount of supervision

While there is a specified number of supervision sessions for trainees (e.g. for their Chartered status) which varies across different sub-disciplines of psychology, no definitive amount of supervision is specified as part of CPD. To determine both the quantity and nature of the supervision, the psychologist may consider their need for supervision from various perspectives: their own assessment of need, the competencies required for their practice; the context of their work; organisational requirements; and the support available. For psychologists in employment the arrangements for consultation/supervision should be agreed after considering these factors in consultation with the employer.

Roles and responsibilities of the supervisor

Psychologists undertaking supervision should ensure that they are sufficiently experienced, competent and appropriately trained to provide supervision. Psychologists are often called upon to supervise non-psychologists, in which case these guidelines would also apply.

In supervision, the psychologist as supervisor needs be aware of their own competence in relation to the work of the psychologist and, where necessary, recommend additional supervisors who may have the appropriate level of expertise. Psychologists may offer consultancy supervision to professional colleagues, organisations and stakeholders in line with their competencies.

Psychologists should avoid personal relationships between the supervisor and psychologist which could adversely affect integrity and objectivity.

Psychologists providing consultation/supervision should do so in line with the guidance in other relevant sections of these Practice Guidelines.

Issues of power and control

The nature of supervision itself creates a power imbalance, even between peers. Both the person providing supervision and the person receiving it need to be aware of this.

The supervisory leadership relationship should be both informative and reflective. Psychologists in leadership roles as supervisors should provide regular, informative feedback to the psychologist as well as motivating them to reflect on their own practice, continue to self-assess and improve self-awareness.

1.6 Leadership

Psychologists at any stage of their career are likely to find themselves in a position where they are required to demonstrate or model leadership. This may be an integral part of their practitioner work or may arise through being a leader of a team, including leading in Society work. Leadership is widely quoted and described in the context of leading change as, *'accepting responsibility to create conditions that enable others to achieve shared purpose in the face of uncertainty'*[5]. Furthermore, leaders 'can create conditions interpersonally, structurally, and/or procedurally'[6]. These descriptors highlight the often complex process of psychological change through clinical intervention and also through leading others.

Contemporary leadership styles are generally more aligned to working *within* a team or a system rather than being directive. Leading as a psychologist is likely to include dealing with highly complex information and systems whatever the context. Leading in this way demands high levels of skill in developing, managing and maintaining professional relationships. This may include communicating complex and sensitive information, and reflexivity to enable individuals and teams to co-formulate around difficulty and challenge.

2. Where psychologists work

2.1 Working environment

When undertaking work with clients, psychologists need to give consideration to providing an environment which is welcoming, accessible, safe, and offers privacy. Although choice of workspace is not always available, it is important wherever work takes place with clients that psychologists consider:

- whether lighting, acoustics, heating and seating are comfortable;
- whether confidential conversations may be audible to others;
- whether there are arrangements to ensure client and practitioner safety, for example through easy access to another member of staff if a difficulty arises;
- whether access and exits are safe, well-lit and in areas which are likely to be overseen;
- that reasonable adjustments can be made to support effects of special needs and/or disability;
- whether the setting is culturally acceptable to clients; and
- whether there are facilities and equipment suitable for the clients, for example lavatories, play materials for children.

Where context of practice allows, psychologists could seek the assistance of relevant workplace representatives, for example their trade union representative or human resources staff, in situations where appropriate workplace conditions are not being provided. However, it is acknowledged that sometimes the ideal workspace may not be available or that psychologists may not have access to these workplace representatives due to their context of practice and psychologists should, within the limits of safe practice, be able to adapt to situations within local constraints in order to provide the best service for clients.

Sometimes, it is important to work with clients in representative environments in order to understand behavioural drivers. This will apply if the psychologist's task is to understand behaviours in such environments and provide support, for example through the use of technology, design of procedures, training or team design. Psychologists should consider carefully how to create representative conditions without causing harm. Equally it may sometimes be necessary for psychologists to work in a client's own context as that is where any intervention may be formulated or put in place. Psychologists should ensure they follow the relevant health and safety guidelines in place at their working location even if that location is not their usual place of work.

There may be a temptation to make assumptions about what sort of environment is most suitable, comfortable and culturally appropriate for clients, however it is helpful to ask them and endeavour to make appropriate adjustments to meet their needs.

Lone working

Many psychologists practise in a lone worker workplace and on occasion visit clients in their own homes. When working at home, it is necessary to ensure the proper insurance and protocols for this type of work, as well as manage boundaries between personal and private space. When working alone, the Suzy Lamplugh Trust recommends always ensuring that someone else has access to schedules and contact details for clients. Psychologists may also want to put in place a 'code word call', where should they fail to answer or speak the correct code word, the police are alerted. This is just an example of an additional safety practice, and there may be different ideas for ensuring personal safety when lone working. However, the important point is to think about keeping safe, have a plan and stick to it. Further information is available in ***Appendix 2: Websites and further information.***

Harassment and bullying

Bullying is behaviour that may take the form of actions or comments that are offensive, which are intended to humiliate, undermine, demean or injure the recipient. It may target an individual or group of individuals and is a form or abuse that may be explicit and therefore obvious, or it may be insidious, an experience recognised only by the recipient and harder to notice by others. Bullying may be vertical (i.e. between managers/ supervisors and staff) or horizontal (i.e. between colleagues). Clients may also experience bullying by professionals. While bullying may involve a misuse of power and be committed in the workplace by a manager, supervisor or senior colleagues (sometimes known as downwards bullying), it should be borne in mind that it is not uncommon for senior staff to be bullied by those whose work they oversee.[7] What can be legitimately classified as bullying may take into account the particular personal sensitivities and characteristics of the person suffering the alleged bullying.

Harassment can be defined as actions or comments that are unwanted and which may be related to age, disability, gender reassignment, race, sex, sexual orientation, religion or belief or any other personal characteristic of the recipient. Harassment occurs when someone engages in unwanted conduct in relation to the aforementioned characteristics and that conduct has the purpose or effect of violating the other person's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the other person.

The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Psychologists with concerns over the above behaviour should seek the support of their supervisor, line manager or other appropriate senior staff member, accredited trade union workplace representative or human resources department. Further information is available in ***Appendix 2: Websites and further information.***

Whistleblowing

Whistleblowing is the disclosure of wrong doing (beyond normal managerial channels) and is important as it is a critical way not only of seeking justice for the individual or individuals affected, but also of developing inside information within organisations about incorrect or unfair practices,[8] thereby increasing the evidence required for corrective action to take place.

A whistle-blower is protected by law (the Public Interest (Disclosure) Act 1998) if:

1. They are a worker (this includes trainees and can include self-employed personnel servicing an organisation in certain circumstances).
2. They are acting in the public interest.
3. The disclosure relates to past, present or likely future wrongdoing which involves one or more of the following:
    - criminal offences (which may include fraudulent actions);
    - a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
    - a miscarriage of justice has occurred, is occurring or is likely to occur;
    - the health or safety of any individual has been, is being or is likely to be endangered;
    - the environment has been, is being or is likely to be damaged; or
    - information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

If the individual has been victimised or if they have lost their job due to whistleblowing, the legislation provides them with the right to take a case to an employment tribunal. Whistleblowing is a complex legal area and it is important that anyone considering it considers appropriate advice, for example from an accredited trade union workplace representative or helpline. The relevant human resources department which will have a policy relating to this, or it may be appropriate to seek formal legal advice. Some organisations such as NHS Trusts have a nominated Director responsible for dealing with disclosure issues who may be contacted directly. The Society is a charity and bound by its objects which do not include providing direct assistance to individual psychologists in these situations by offering advice. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists can inform on all aspects of the establishment of workplace cultural norms that promote positive managerial and leadership behaviour and can help facilitate the development of cultures that support the disclosure of inappropriate practices. Psychologists are also appropriately qualified to support workers who have been subject to bullying or harassment or who are contemplating or indeed have already ‘blown the whistle’. Whistleblowing, and even the prospect of such, can create traumatic responses in workers[9] and can lead to retaliation as a consequence. Empirical evidence highlights the link between whistleblowing and the devastating effects on health that may follow, such as depression, anxiety and symptoms relating to post-traumatic stress[10]. Psychologists are able to work with affected employees and in a consultative capacity with organisations to manage work-related stress disorders caused by these incidents of bullying, harassment and whistleblowing to lessen the risk of absenteeism and to facilitate a return to work following a period of absence. Further information is available in ***Section 8: How to respond when things go wrong.***

2.2 Working in the digital age

Digital media continues to advance in terms of choice and functionality. It is becoming increasingly common for psychologists in particular when working with clients to make use of the internet and/audio-visual technology. These technologies require the psychologist to ensure that the network used is as secure as reasonably possible and, as far as is feasible, assures privacy to their clients.

There can be no guarantee of security when using the internet, and voice over internet protocol (VOIP) services such as 'Skype' or 'FaceTime' are no different, as they use the same data infrastructure as the rest of the internet.

Most, if not all, VOIP systems encrypt the voice into waveforms during digital transit across the internet, and it would be impossible to eavesdrop on these data packets in real time. However, the information is potentially vulnerable to eavesdropping/compromise before encryption by the speaker's system, and after decryption by the listener's system. This will depend upon the security measures in place for the end user's (speaker and listener) own networking infrastructures, be that a company, institution or home user. If an end user's computer has been compromised by any form of malware, then there will be a risk of eavesdropping, data theft and/or denial of service.

The risk for eavesdropping on VOIP systems is no more or less than that of traditional analogue phone systems, and both would require specialist knowledge, equipment and software to be achieved. However, it is recommended that only fit-for-purpose VOIP systems are used, and that public networks, such as Social Media sites, are avoided for VOIP communications. Further information is available on the ***Society website: http://beta.bps.org.uk/Practice-Guidelines.***

Some employers may have their own rules about which media are acceptable to use. The USA has the Health Insurance Portability and Accountability Act (HIPAA) which sets standards for security for electronic data. There is no such provision in the UK to date, and so psychologists must satisfy themselves that any media used to communicate personal data is secure. This is a rapidly changing area and so technology-specific guidance has not been provided in this document. Further information is available in ***Section 7.1: Information governance*** and ***Appendix 2: Websites and further information.***

The use of online 'Apps', computer assisted decision-making and artificial intelligence in psychological practice and research is evolving rapidly. When recommending or using computerised systems psychologists should pay due regard to peoples' health, wellbeing and safety being mindful of Clinical Safety Evaluations, Medical Device Evaluations and other relevant guidance such as NICE.

Use of social media

Many psychologists are using social media, networking sites or blogs to communicate with friends, family, professionals, colleagues and clients. This specific guidance therefore addresses the use of social media by psychologists, and provides practical advice for using them responsibly. Further information is available in ***Appendix 2: Websites and further information.***

Psychologists should:

- Remember that social networking sites are generally public and permanent. Once something is posted online, it remains traceable even if it is later deleted.
- Keep their professional and personal life as separate as possible. This may be best achieved by having separate accounts for work-related communications to those for friends/family.
- Consider whether, in their context of practice, it is appropriate to accept 'friend' requests from current or past clients, if necessary, decline the request via more formal means of communication. It is highly unlikely to be appropriate to accept in a clinical or forensic context.
- Be minded to act responsibly at all times and uphold the reputation of the profession, whether identified as a psychologist or not on the social media platform.
- Be aware that social networking sites may update their services and that privacy settings can be reset to a default that deletes personalised settings.
- Remember that images posted online by family or friends may be accessible, as they may not have set privacy settings as tightly.
- Be minded that social networking sites can make it easier to engage (intentionally or unintentionally) in professional misconduct.
- Report the misconduct of other psychologists on such social networking sites to any relevant parties (such as the employer or the HCPC).
- Be aware of their employer's social media policy.

Psychologists should not:

- Establish inappropriate relationships with clients online.
- Discuss work-related or confidential issues online in any non-secure medium.
- Publish pictures of clients online, where they are classified as clinical records.
- Use social networking sites for whistle-blowing or raising concerns.
- Post defamatory comments about individuals or institutions. Defamation law can apply to any comments posted on the web, irrespective of whether they are made in a personal or professional capacity.

2.3 Working for the court

Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion.

Psychologists are responsible for ensuring they are sufficiently competent and expert in offering an opinion. It is not appropriate for trainee or assistant psychologists to act as expert witnesses. Indications of competence in respect of the knowledge required by the court, and expertise within a specialised field, may include:

- qualifications and/or degree(s) in the areas(s) in question;
- a number of years of post-doctoral/post-qualification experience;
- academic, professional and scientific publications in relevant areas;
- demonstrations of professional practice, competence, specialist knowledge and expertise with a bearing upon the issues in the case; and

- current experience in applying psychology in the area of claimed expertise.

It follows that a psychologist with trainee or assistant status is unlikely to have the necessary experience and qualifications to be retained as an expert witness by a legal firm. However, trainees or assistants who have written reports on individuals in the course of their employment may be required to give evidence (for example, at a tribunal). If so, they should bear in mind that only qualified psychologists should give evidence of opinion, and that their supervisor is responsible for the professional quality of their work in this situation as in all others.

Psychologists instructed as experts need to ensure that they can provide an independent and impartial opinion, and that their independence is clear to all. Any potential conflicts of interest should be made explicit and should be reported as soon as they arise. This can extend to being asked to provide an expert report on someone the psychologist is providing with therapy as an ‘Applicant’, ‘Claimant’ or ‘Complainer’. This dual relationship is an unacceptable conflict.

When lawyers seek to introduce expert psychological evidence, it is the judge in the case who decides whether an individual has the requisite expertise to give evidence with the potential to be relevant to the case. The judge also decides whether what the expert asserts is relevant and, therefore, admissible in law.

Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert’s overriding duty is to help the court on matters within their expertise and that this duty overrides the expert’s duty to the person from whom they are receiving instructions. Any report must be written in accordance with the criteria in Practice Direction 35.

Further information is available in ***Society documents: Psychologists as Expert Witnesses: Guidelines and Procedure*** and ***Psychologists as Expert Witnesses in the Family courts in England and Wales.***

2.4 Working for defence and security organisations

Psychologists may work with defence and security interests in many different capacities. This may include supporting military or security personnel to perform their roles through the development of skills and behaviours, supporting the mental health and wellbeing of people affected by threats, activities and events in this context, and offering advice and consultancy. It is also UK Defence practice to enlist uniformed psychologists for roles associated with psychology. However, in general, psychologists in defence will be in a civilian role and therefore not under military command.

While there is a strong sense of common culture within the defence and security sectors, there are also important variations. For example, each of the armed forces has its own organisational culture resulting in different attitudes and behaviours. There are also differences within different sectors of each organisation. All these differences are very important to the individuals concerned, forming a large part of their sense of identity.

Psychologists working with these populations should ensure they investigate and acknowledge cultural differences, particularly when working with other national cultures. They should also take careful account of the environments in which people are living and working. Psychologists can be working with civilians and/or members of the armed forces who are operating in life threatening environments and are required to make decisions under extraordinary pressure. It is usually invalid to extrapolate from behaviour in benign conditions to behaviour under threat, hardship and stress.

3. Who psychologists work with

3.1 Working with Experts by Experience

In relevant services it is best practice for psychologists to work collaboratively with clients and Experts by Experience in developing and delivering all aspects of psychological services. In mental health, the Government is committed to shared decision-making and the principle ‘no decision about me without me’[11]. This applies from work with an individual client through to changes in government policy relevant to the services provided by psychologists. Psychologists should develop services, policies and guidelines in collaboration with the people who use their services.

In professional practice it is important and helpful to work collaboratively with clients and, where relevant, others in order to ensure that the application of psychological research and theory is understood by and adapted appropriately to the client group and context, which may differ from the populations on which the research was based.

3.2 Working with assistants/interns

Many graduate psychologists take up assistant psychologist positions on either a paid or an unpaid basis.

The following (non-exhaustive) list provides examples of activities which can be carried out by assistant psychologists/interns. This list can guide those who are working as assistant psychologists/interns to request or refuse a task or assignment, as well as assist those who are practising and supervising to observe boundaries and limitations:
- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

An assistant psychologist/intern should not be employed to:
- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

In occupational settings, the issue of appropriate supervision and guidance is of particular importance when the needs of individuals and organisational demands need to be balanced. Appropriate mechanisms need to be in place to ensure that no assistant psychologist/intern is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue).

In clinical and forensic settings, there are some additional limitations, related to the clear delineation between qualified and assistant psychologist/intern, as follows:

- An assistant psychologist should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist.
- When an assistant psychologist is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the assistant's work. This means the qualified psychologist should attend the hearing also, as there may be questions which an assistant cannot answer. Both should bear in mind that an assistant is not qualified to give evidence of opinion.
- An assistant psychologist should not undertake tasks in areas where there is not a competent supervisor.
- An assistant psychologist should not carry out the duties of a care assistant.

The managing or supervising psychologist has a responsibility to ensure that assistant psychologists are not given work to do that is over and above their level of competence. Further information is available in ***Society Document: Applied practitioner psychologist internship programmes and unpaid voluntary assistant psychologist posts.***

3.3 Working with trainee psychologists

The Society's standards related to working with trainees across the domains of applied psychology are set out in the Standards for accreditation of training programmes. These set out: the required core competencies that trainees need to develop, the curriculum and assessment requirements that programme providers need to deliver against, and the requirements of supervised practice; expectations around trainees' understanding of and ability to work ethically and legally; selection and recruitment of trainees; personal and professional development of trainees whilst in training; academic staffing and leadership for accredited programmes; and expectations in relation to quality management. Psychologists working with trainees as practice educators should familiarise themselves with these standards and adhere to them in their work with trainees. Further information is available on the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

3.4 Working with multiple clients

Psychologists will sometimes be in situations where their client will not be one clear individual or group, for example, a psychologist may be employed by an organisation to provide assessment or psychological support for employees. Psychologists need to consider and be mindful of the demands that this might place on their ethical practice and how this might lead to conflicts of interest.

Identification of the following client hierarchy may be considered[12],[13]:

- Primary client – the person or persons with whom the psychologist is interacting directly: the recipient of a psychological service.
- Commissioning stakeholders – the organisation or overall commissioning body that has sought the psychologist.
- Others affected by the primary client's actions – the customers of the organisation or service, or the personal acquaintances, friends and family of the primary client. In some circumstances, this will be the general public or larger groups interested in the outcomes of the intervention.

The psychologist's role will be mainly to the primary client and then the commissioning stakeholder. It is paramount that issues around boundaries and sharing of information are made explicit and addressed appropriately through a clear contracting agreement. Further information is available in ***Section 3.5: Working with other professionals, Section 5: Making and maintaining agreements*** and ***Section 7: Managing data and confidentiality.***

Within each of the levels of the hierarchy, varying allegiances to associates (friends, family, acquaintances, colleagues) will need to be attended to, as will consideration of the impact of professional activity on the reputation of the profession and all those concerned.

3.5 Working with other professionals (including in multi-agency settings)

In order to meet the complex needs of clients fully, psychologists will often be required to work collaboratively with other professionals from their own or other agencies.

Such collaborative working will be for the benefit of clients and/or the promotion of the safety and protection of the public or the benefit of the organisation, and is required by national policy and legislation in a number of areas in which psychologists work. Engaging in partnerships drawing on a wide range of services and agencies enables psychologists to address identified community issues with the optimum use of resources.

Where appropriate to their context of practice, and consistent with the requirements of psychological practice, psychologists should:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.

- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety.
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

3.6 Boundaries in professional relationships

Psychologists seek to establish good relationships and trust with their clients, other professionals, organisations and the community. They are aware of the complexity of professional relationships and the need to observe their boundaries. Multiple relationships occur when a psychologist is in a professional role with a client or colleague and at the same time is in another role with the same person or group e.g. as a supervisor, sports club member or co-author in a publication or where a psychologist is asked to work at a school where their child is a pupil.

Psychologists should:
- Ensure that the relationship reflects the appropriate context within which the practice is taking place.
- Be aware of the issues of multiple relationships and professional boundaries which may lead to (real or perceived) conflicts of interest or ethical considerations.
- Clarify for clients and other relevant stakeholders when these issues might arise.

When acting as leaders in practitioner or managerial roles, psychologists should maintain an awareness of the importance of respect for boundary and power issues within leadership relationships. In particular, an awareness of the possible abuse of these relationships should be maintained at all times. It is important that psychologists explicitly define the boundary of the relationship and negotiate and respect the responsibility that each holds in relation to it. Where psychologists are in a position of power/leadership with individuals, it is particularly important that they exercise caution and consider the possible issues which may arise from developing a personal relationship with these individuals. It may be necessary to seek further supervision where appropriate, with additional peers as necessary.

Psychologists have a duty of care towards their clients, who may be vulnerable, and should maintain a professional emotional distance from clients, services users or relatives and should not enter into an intimate or sexual relationship with any clients, service users or relatives they come into contact with as part of practice. Psychologists should also be aware that their duty of care can continue after a client practitioner relationship has ended.

As far as is reasonably practical, psychologists should not enter into a professional relationship with someone with whom they already have, or have had, a close personal relationship. This includes family members and friends. Where there is no reasonable alternative, such as a lack of availability of other professionals, and it is acceptable in the particular context of practice, the psychologist should make every effort to remain professional and objective while working with the individual they know or have known. In such circumstances, at the earliest possible opportunity, this should be disclosed and discussed with a manager, where there is one, and supervisor and a note should be made in client records.

A range of psychologists work with people who initially have accessed the services in a dependent position, and have then transitioned to becoming partners and colleagues in service and policy development and design. The nature of the work becomes more collegiate and the psychologist holds multiple roles including facilitating participation, adapting communication and advocacy.

3.7 Working with children and young people

When seeking to work with children and young people, psychologists should consider how they can develop ways of communicating with the child or young person that will be most effective in ensuring they can express their views and feelings.

In most instances psychologists will use their specialist professional training and experience working with children, young people and families in order to understand the developmental needs of the child or young person in question; where a psychologist does not have specialist training that has included children and young people then there would be an expectation that advice or supervision should be sought before working with a child, young person, or their family. Similarly, work with children, young people and their families should take account of wider systemic factors outside of the child or young person; this will usually involve the child's family and may also include their school, and other settings.

As with adult clients, there can be misunderstandings and confusions about the role of a psychologist, the nature of the work being undertaken, and the possible outcomes of the work. It is essential to ask the children and young people about their understanding of what is happening on a regular basis (this may be appropriate at each session) and address any confusion that has arisen.

When working with children and young people, psychologists are advised to ensure that they have ascertained who has parental responsibility and that those with parental responsibility are aware of their planned involvement, if this is appropriate. Psychologists working with children, young people and families need to be aware that young people who are deemed to be competent to make their own decisions: 'Gillick competent'[14] can give their own consent to involvement with a psychologist, and that if a young person gives consent under these circumstances, then parental consent is not required. Similarly, a young person who is 'Gillick competent' can give consent even if parents have declined to give consent; such young people can also ask that parents are not informed of any involvement, and this should be respected by the psychologist; an example here would be in a school setting where a young person may give their own consent to see a psychologist and may ask for parents not to be informed. Psychologists also need to be aware that where separated or divorced parents share parental responsibility, one parent can give consent.

3.8 Working with people with intellectual disabilities and impaired cognitive abilities

Psychologists are likely to work at some point with a range of people whose cognitive abilities are either temporarily or permanently altered, either by organic or developmental changes. Appropriate assessment of the abilities and skills is required, so that adaptions can be made to further interventions, treatments or management. The implications of the cognitive abilities on the person, their family and the reason for psychology involvement, will need to be considered.

Psychologists working with people with intellectual (learning) disabilities will need to consider adaptations to their approach to ensure the service they are offering is clearly understood, and is adapted to the individual's preferences, strengths and needs. This can include considering adaptations to oral or written communication, psychological assessment, intervention, and outcome evaluation.

Psychologists will need to be flexible and to make reasonable adjustments to their usual practice to ensure an appropriate service is offered. Psychologists should ensure their work is person-centred and respectful of the individual's needs, whether that work involves working with the individual with intellectual disabilities directly, or whether it also includes, or even may predominantly involve, working indirectly with family, carer or professional systems around the individual.

Psychologists will need to be mindful of the range of complex factors that often affect people with intellectual disabilities (e.g. communication needs, poorer mental and physical health outcomes and healthcare service experiences, unemployment, disempowerment, social isolation and exclusion, including experiences of bullying, abuse and hate crime, being overrepresented in the prison population, among others) and, therefore, the specific policy and practice guidance that applies. Further information is available in ***Section 4.2: Safeguarding adults at risk of harm*** and ***Section 6.3: Informed consent with people who may lack capacity.***

3.9 Working with detained people

Where clients are detained involuntarily there will always be a legal framework within which professionals must practise, and they should be aware of how their work fits into that framework. Involuntary detention is not only covered by professional rules and national legislation, but also by international agreements.

Psychologists should be aware that having the approval of one's employer is not necessarily a guarantee that practice is either ethical or legal, as described for example in the Hoffman report[15]. Where practitioners have doubts about the legal or ethical acceptability of employer demands, they should seek advice from an accredited workplace trade union representative, a human resources department, or appropriate helpline. They should follow their organisation's guidelines on raising concerns at work. Seeking advice outside the immediate setting is helpful as colleagues within the workplace may be subject to the same pressures as they are.

Under the headings below, the role of the practitioner can be seen to be key to the way that detained persons are understood, and this can have a great impact on the way that their cases are handled by the detaining authority. The practitioner therefore has considerable power, whereas the client has very little. This power imbalance should always be borne in mind by practitioners dealing with detained persons. They should also bear in mind that the imbalance can be implicit as well as explicit.

Prisoners

Putting psychological pressure on detained persons to obtain a confession to an offence is illegal under the UN Convention on Torture[16]. In this context, 'psychological pressure' could well include such things as telling indeterminate-sentence prisoners who maintain innocence that they are unlikely to be released unless they engage with an intervention that relies on acknowledgement of guilt. Decisions about release are not the role of the practitioner, unless they are directly involved with, or are a member of the release authority, with a delegated role in the formal decision-making process. An approach to engagement such as this would not be considered beneficial to the client. However, those instructed by any party to the formal Parole Board decision-making process may properly be asked to give an opinion on suitability for release.

Practitioners dealing with detained offenders who have committed violent or sexual offences should guard against being morally judgemental. It is routine for practitioners in this field to encounter offenders who have committed very unpleasant acts with whose victims they can readily identify. Psychologists should be mindful that their own views about a client do not impact on their work.

Care should be taken when working with detained persons whose literacy is poor or whose first language is not English, and who cannot read a report which has been written about them. Even clients who are literate in English will probably not be familiar with psychological terminology, and may need considerable time to read and fully digest a report. People who are detained can also have cognitive challenges or intellectual disabilities which might make this process more difficult.

Persons detained under immigration legislation

Detained people may be afraid of raising a particular topic in case it is misunderstood, or too embarrassed because of cultural standards. For example, in some cultures it is difficult or unacceptable to discuss sexual matters, but sexual violence has been suffered by many asylum seekers in conflict zones, and some discussion of it may be essential in assessing their case. Even within the same culture there can be considerable generational differences.

Psychologists should guard against unwarranted interpretations of psychological evidence by commissioners or authority figures. For example, reporting that someone's story shows inconsistencies may give the impression that they are lying. This may be the case, but inconsistencies alone are insufficient proof of this. It is commonplace for evidence to be inconsistently reported when people have been through traumatising experiences in areas of conflict, as is often the case with persons detained under immigration legislation.

Practitioners should take particular care in dealing with detained persons whose first language is not English. The opportunities for misunderstanding in both directions should be obvious, and in many cases the correct procedure will be to interview with the help of an interpreter. Failing to use interpreters when it was clearly appropriate to do so could inappropriately compromise the quality of the psychologist's work.

Mental Health Detentions

Mental Health Act 1983 as amended 2007 (England and Wales)
Under the Mental Health Act (MHA) a person can only be detained for treatment if that person is suffering from a mental disorder of a nature of degree that makes it appropriate for them to receive medical treatment in hospital. In the Act 'mental disorder' is defined as 'any disorder or disability of mind'. This definition is very broad but the *Code of Practice* provides guidance on clinically recognised conditions that fall within its meaning. Major categories of mental illness (e.g. affective disorders, schizophrenia and organic mental disorders) are included along with personality disorders, autistic spectrum disorders and learning disabilities (the latter only if accompanied by abnormally aggressive or seriously irresponsible behaviour). Dependence on alcohol or drugs is not considered a mental disorder under the MHA.

In the Act, all 'medical treatment' including psychological interventions is for the purpose of alleviating, or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations. The medical treatment must be required for the health and safety of the client or for the protection of others. This means that the primary purpose of psychological interventions offered and provided to detained persons has to be to reduce the risks that their mental disorder presents to the detained person or others; as once those risks are reduced or minimised the client will no longer require detention and can progress to a less restrictive environment. This requirement points to the importance of an individualised formulation of a client's treatment needs that includes a careful assessment of the risks to self and others (see section on Risk Assessment, p.32).

Under the MHA appropriate medical treatment must be available. This is described as the 'appropriate medical treatment test' in the *Code of Practice*. Such treatment must have the *purpose* of alleviating or preventing a worsening of the disorder or its symptoms or manifestations, even if it cannot be shown in advance that the treatment is likely to have an effect for a particular patient. Thus, appropriate medical treatment need not be likely to achieve those purposes. That is, purpose is not the same as likelihood. The nature and degree of the patient's mental disorder and all the patient's particular circumstances are all relevant to whether the treatment is appropriate.

The appropriate medical treatment test is designed to ensure that patients are not detained for treatment unless they are actually to be offered appropriate treatment for their mental disorder. Thus, the MHA requires only that appropriate treatment is available to a detained patient. The patient's refusal to accept treatment is not an obstacle to detention, so long as appropriate treatment is available.

This has particular relevance for psychological therapies. The Code at chapter 23.20 states:

> *In particular, psychological therapies and other forms of medical treatments which, to be effective, require the patient's cooperation are not automatically inappropriate simply because a patient does not currently wish to engage with them. Such treatments can potentially remain appropriate and available as long as it continues to be clinically suitable to offer them and they would be provided if the patient agreed to engage.*

Whilst the availability test of appropriate medical treatment applies to psychological interventions in the same way as for other forms of treatment, it is important for psychologists to avoid placing pressure on clients to participate in such treatment. In order for there to be an effective therapeutic alliance there needs to be trust and this only develops in the absence of coercion. Psychological therapy works when the client decides they are ready for therapy and freely consents to it. There is an inevitable power differential in favour of the clinician. Thus, every attempt should be made to emphasise patient involvement and choice and to avoid coercion in a manner consistent with the *Code of Practice* empowerment and involvement and respect and dignity principles. Further information is available in ***Section 6: Obtaining informed consent.***

The Mental Health Act 2007, which amended the MHA 1983, introduced approved clinicians (AC) who may be drawn from a defined group of professions, including practitioner psychologists listed in the register maintained by the Health and Care Professions Council. ACs are approved by the appropriate national authority to act as an approved clinician for the purposes of the MHA 1983. Responsible clinicians (RC) are ACs who have overall responsibility for an allocated patient's case. The Code of Practice at chapter 36.3 says that a patient's RC should be the available AC with the most appropriate expertise to meet the patient's main assessment and treatment needs. At chapter 36.5 the Code says that where psychological therapies are central to a patient's treatment then it may be appropriate for a professional with particular expertise in this area to act as the RC.

Chapter 39 of the *Code of Practice* provides guidance on the circumstances in which potential conflicts of interest may prevent designated professionals from making an application for or recommendations supporting a patient's detention or guardianship. The potential conflicts of interest dealt with in the Code involve financial, business, professional and personal issues.

The Mental Health (Scotland) Act 2015.

This act, together with the Mental Health (Care and Treatment) (Scotland) Act 2003 sets out the law for detaining patients and restricting patients. For patients to be detained, this has to be considered by the Mental Health Tribunal for Scotland. This applies, for example, to those detained in the NHS who are not subject to a court (forensic) decision.

Restricted patients are 'detained in hospital under a compulsion order with a restriction order'. They have usually committed an offence punishable by imprisonment but as a result of mental disorder are not imprisoned but ordered to be detained in hospital for treatment, without limit of time. They are dealt with through a programme of treatment and rehabilitation – the aim being to prevent recurrence of offending by dealing with the mental disorder'.

Risk assessment

When dealing with detained people seeking release, such as parole applicants or patients seeking release from a mental health tribunal, risk assessment (usually for violence risk) will be a prime consideration. Psychologists should bear in mind that risk assessment is not prediction. Risk assessment instruments are rarely more than about 70 per cent accurate when predicting reconviction and many items on commonly used risk-assessment schedules are of poor predictive value.[17] Psychologists should also bear in mind that risk-assessment instruments are better at identifying low-risk than high-risk individuals[18],[19]. A statement of risk is not a prediction about an individual, but a statement based on the behaviour of a criterion group with which that individual is being compared. Risk is statistical by its very nature, and the value of such comparisons depends upon the individual's similarity to the criterion group upon which the risk assessment instrument was developed. Accuracy may be greatly reduced if the similarity is low[20]. It may be better to think of risk assessment as a process of identifying those risk factors which need to be monitored and controlled if supervision of the individual is to be reduced or withdrawn.

3.10 Working with people who are, or would like to be employed

Psychologists are sometimes commissioned to deliver psychological assessment or training with employees and potential employees. Psychologists should take particular care over the advice provided in follow-up reports, as employers are not trained professionals and may misinterpret advice or psychometric testing results. For example, citing a reading ability level using age is misleading, and could be interpreted as incompetent for the role, when in reality the role does not require a high reading level or a reasonable adjustment could be provided.

Similarly, psychologists should ensure that the tools they are using to assess competence or suitability are appropriate for the role, and have good reliability and validity. Any tools devised by the psychologist are likely to be interpreted by the employer as professional and authoritative, where there is ambiguity or multiple interpretations, this must be made clear, so that decisions about peoples' employment are not made in error.

There are people who work or who would like to work, who may experience cognitive difficulties caused by a range of factors, for example intellectual disabilities, dementia, acquired brain injury. Sometimes this information is known and needs to be considered when assessing and advising. At other times, this possibility of a cognitive or intellectual impairment needs to be considered. The impact of this can be far reaching, in terms of ongoing or future employment, access to benefits and of course associated psychological adjustments for the person and the people around them. Further information is available in ***Section 7: Managing data and confidentiality*** and ***Society Document: Psychological Assessment of Adults with Specific Performance Difficulties at Work.***

3.11 Working with cultural difference

It is expected that all psychologists will have the necessary skills and abilities to work with all sections of the community.

Psychologists need to be aware of stereotypical beliefs and assumptions which manifest in thinking about culture and ethnic groups. Psychologists should bear in mind the history of racism and the early development of Western psychology[21] and culturally biased testing in favour of white, middle-class children. Psychologists need to recognise that multi-ethnic groups are not homogenous groups and there are wide regional and local differences among these groups which can be split by language, dialect and regional variations. Each ethnic community has a distinct identity and religious focus may also vary within and across communities.

Race is not a biologically meaningful concept to apply to people, and even the artificial divisions between the so-called racial groups are nebulous and unstable, biologically, socially and physically.[22]

Psychologists need to understand the discrimination suffered by people from diverse and/or minority ethnic and religious backgrounds as a result of:
- the interchangeable use of the terms race, culture and ethnicity leading either to the perception of black and minority culture, race and ethnicity as unitary or an assumption that knowing about these cultures solves the problem of equality, fairness and availability of services;
- the maintenance of the colour-blind approach in service where 'one size fits all', resulting in a lack of formal recognition of the varied diverse needs as well as these needs being ignored, unacknowledged or assumed to be the same;
- the lack of appropriate culturally relevant psychological therapy available to certain Black and Minority Ethnic (BME) communities;
- being discriminated against on grounds of 'special' needs, effectively considered as 'cultural pathology'; and
- experiencing instances of indirect, subtle, or unintentional discrimination often called 'micro-aggressions'.

It would be expected that all practising psychologists should develop a productive working relationship with culturally and linguistically diverse groups of people by:
- avoiding different types of biases and find new ways (verbally and non-verbally) to build rapport and respect;
- using and working with trained interpreters in assessment, formulation and intervention work as well as research work;
- being aware of the impact of culture, ethnicity and religion in assessment, formulation and intervention processes and the use of norm-referenced tests which do not include minority ethnic groups as part of their standardisation;
- pre-assessing and pre-incorporating ethnic identity (including its fine gradations, region, class and generation) which can have impacts on processes and outcomes of psychological work;
- acknowledging their own ethnocentricity and possible underlying socially conditioned prejudice to people who are 'different'; psychologists need to acknowledge that people can change, irrespective of their differences and psychological distress;
- relooking at current models of mental health which traditionally reflect Western

constructions, and incorporating other world views of psychological wellbeing; and
- understanding and respecting the different concepts of health and illness that exist within different ethnicities, including newly arrived people from Europe and refugees from Syria, Turkey, Somalia etc.

Psychologists need to: address the different life situations and life circumstances experienced by users who wish to use mental health services; hear their voices based on their personal experiences; and act and respond accordingly in a human way.

3.12 Working with people of faith, religion and spirituality

In working with clients who hold a variety of values and religious and spiritual beliefs which may be different from their own, psychologists should consider the following:
- Psychologists should respect clients' values and spiritual beliefs and need to be mindful that their personal beliefs should not be an impediment to engaging with the client.
- Spiritual beliefs are very often beneficial to the client's wellbeing and may be helpful to be incorporated into any intervention to achieve a positive impact where appropriate.
- In some circumstances the client's faith belief may be harmful or detrimental to themselves or others.

3.13 Working with sexual and gender minorities

Psychologists are committed to the fair treatment and inclusion of people who are intersex, people who do not identify as heterosexual and/or people who do not identify with their natally-assigned sex. This section provides guidance to address specific issues in support of these heterogeneous populations. In these guidelines we use the term 'sexual minority(ies)' to refer to individuals whose romantic attraction or sexual attraction is other than heterosexual (different from the majority in the surrounding society), and the term 'gender minorities' to refer to transgender, genderqueer and intersex individuals.

When working with gender and sexual minorities, psychologists are encouraged to:
- remember that sexual and gender minority identities are not indicative of mental health disorders;
- understand that attitudes towards sex, sexuality and gender are located in a changing social, cultural, and political context, and to reflect on their own understanding of these concepts and how it may impact their practice;
- reflect on the limits of their practice when working with certain sexual and gender minority clients, and to consider appropriate referral and training when necessary;
- understand how social stigmatisation (e.g. prejudice, discrimination and violence) poses risks to gender and sexual minority clients;
- consider engaging with the wider socio-political context regarding sexual and gender minorities in order to reduce social stigma;
- be knowledgeable about the diversity of sexual and gender minority identities and practices;

- use the preferred language of the sexual and gender minority individuals;
- understand the unique and particular circumstances and challenges facing clients with diverse gender and sexual identities and practices;
- understand the diversity of forms of relationships and families in gender and sexual minority clients;
- be aware of the potential challenges facing sexual and gender minority clients in their relationships and families;
- be mindful of the intersections between sexual and gender minority and socio-cultural/economic status;
- recognise the particular challenges experienced by gender and sexual minorities with physical and/or mental health difficulties;
- recognise the diversity of developmental pathways for sexual and gender minority children and adults;
- recognise the needs and issues of young people from gender and sexual minorities, and their particular vulnerabilities;
- support the self-determination of their clients in the development of their identities and practices; and
- avoid attempting to change gender or sexual minorities on the basis that they can be 'cured' or because of stigmatising theory, personal, religious and/or socio-cultural beliefs.

Working with racially and ethnically diverse Lesbian, Bisexual, Gay, Trans*, Queer (LGBTQ) populations

Black and minority ethnic (BME) LGBTQ people have to negotiate between the values and beliefs of the mainstream and minority ethnic cultures. Cultural differences in norms, beliefs, and values can be a source of psychological stress[23],[24],[25]. There may be no particular sexual and ethnic minority group to which a BME LGBTQ person can anchor their identity and obtain acceptance and support. This may be a particular issue for BME LGBTQ youth who are exploring their sexuality and sexual identity.

When offering psychological services to racially and ethnically diverse LGBTQ populations, it is not sufficient for a psychologist simply to identify the racial and ethnic identity and background of the client. Ethnic minority status can complicate and exacerbate the issues, challenges and difficulties the client experiences. The client can be affected by the way their ethno-culture community view and understand sex, sexuality and gender. The issue of racism within the LGBTQ community is also an important issue to consider[26],[27],[28],[29]. Sensitivity to the complex dynamics associated with factors such as cultural values about gender roles, religious and procreative beliefs, degree of individual and family acculturation, and the personal and cultural history of discrimination or oppression is also important. All of these factors may have a significant impact on identity integration and psychological and social functioning[30],[31],[32],[33],[34].

Further information is available in ***Society Document: Guidelines and Literature Review for Psychologists Working Therapeutically with Sexual and Gender Minority Clients.***

3.14 Working with people who may be socially excluded

Social exclusion refers to the extent to which individuals are denied access to the prevailing social system and the right to participate in key areas of social, economic and cultural life. This exclusion occurs due to constraints and restrictions rather than as a matter of choice. Exclusion is typically a result of poverty and/or belonging to a social minority group. The impact of social exclusion has been well documented and leads to the perpetuation of cycles of inequality for individuals and groups. These cycles of inequality are perpetuated in terms of income, health, opportunity, relationships and life-span. Further information is available in ***Society Document: Socially inclusive practice.***

Social inclusion is the process where the needs of all members of communities and the groups which constitute them are recognised, prioritised and met, resulting in these individuals feeling valued and respected. Promoting social inclusion is a broader task than promoting equality and tackling discrimination and stigma. It requires psychology professionals to address wider structural issues in society which maintain excluding processes and power differentials.

The range of individuals and groups who may experience disadvantage and exclusion is not limited to the protected characteristics outlined in the Equality Act. For example, people may also experience exclusion because of their age, they are a carer or are in care, they have a low income or low educational achievement, or their cognitive ability is compromised.

When working towards social inclusion psychologists are encouraged to:
- acknowledge, understand and respect the diversity of the communities in which they practise;
- make adjustments where possible and needed, to enable people to fully participate, e.g. to communication, access to services, adaptation to materials and psychological assessment and interventions;
- recognise that they have a professional duty actively to promote equality and opportunity;
- recognise the shame and distress caused by discrimination, and the impact of discrimination on wellbeing;
- acknowledge and respond to the trauma and distress caused by exclusion;
- move beyond the level of the individual and recognise that social exclusion is a structural issue, and that inclusion will be achieved only by structural changes in society and broad policy initiatives;
- acknowledge that there is a responsibility to highlight the links between structural societal factors and mental health problems;
- make employers, policy-makers, clients and the general public aware of situations where policies, practice and the distribution of resources are oppressive, unfair, harmful or illegal;
- challenge social conditions, both as individuals and collectively, that contribute to social exclusion and stigmatisation;
- make services accessible in terms of time, space, familiarity and comfort; make reasonable adjustments to services to meet individuals' needs; people need to be able

to get to places, get into places, feel welcomed to places and feel that they belong in places;

- recognise that inclusive services reflect the communities they serve in terms of the identities and diversity of the staff team;
- recognise the range of interventions that can improve clinical and social outcomes and use influence to ensure these services are commissioned;
- emphasise social outcomes and participation alongside clinical outcomes;
- maintain an emphasis on empowering clients to achieve their social goals; and
- identify natural sources of support and reciprocal relationships for individuals within their communities, and seek out opportunities to help individuals transition out of formal mental health services.

4. Safeguarding

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect[35]. This guidance addresses safeguarding of both children and adults.

Abuse takes many forms and cuts through various domains of life. The categories below are often referred to in investigation/legislation context and are not mutually exclusive with e.g. emotional abuse featuring in the other domains of abuse. Abuse can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

- Physical abuse – is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This could include hitting, poisoning, deprivation of food, water or liberty, rough handling or exposure to heat or cold, amongst other things.
- Sexual violence and abuse – sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities such as: indecent exposure, stalking, grooming or being made to look at, or be involved in the production of sexually abusive material, or being made to watch sexual activities.
- Psychological/emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, blaming, controlling, intimidation or coercion amongst other things.
- Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not, or could not, consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property of inheritance.
- Institutional abuse is the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk reside in or use. Institutional abuse may occur when routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. It may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.
- Neglect is the persistent failure to meet basic physical and/or psychological needs. It may involve a parent or carer failing to provide adequate food, clothing and shelter, failing to provide or unresponsiveness to, basic emotional needs or failing to protect from physical harm.

Psychologists are in a particularly relevant position to identify interactions or circumstances that affect health and development. This applies not only to psychologists who undertake direct work with children and vulnerable adults in a variety of settings; but also to those who work with clients, seen for instance in clinics, hospitals or prisons, who may make historical disclosures of abuse or raise concerns about child protection or the welfare of people within their families or communities. Safeguarding is thus the responsibility of all psychologists whatever their role.

4.1 Safeguarding children

The Society endorses *Working Together to Safeguard Children* – A guide to inter-agency working to safeguard and promote the welfare of children[36]. Safeguarding children is the responsibility of everyone.

The guidance defines safeguarding children as protecting children from maltreatment and preventing impairment of children's physical or mental health or development (physical, intellectual, emotional, social and behavioural). Promotion of welfare is defined as ensuring that children grow up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances.

Child protection within safeguarding refers to the activity that is undertaken to protect specific children who are suffering or likely to suffer significant harm. For the purposes of child protection legislation children are those who have not yet reached their 18th birthday. The child's needs are paramount, and the needs and wishes of each child be they a baby or infant or an older child, should be put first, so every child receives the support they need before a problem escalates.

The policy of Working Together is underpinned by two key principles: (a) safeguarding is everyone's responsibility and for services to be effective each professional and organisation should play their full part; and (b) safeguarding requires a child-centred approach based on a clear understanding of the needs and views of children.

Where there are concerns that a child is at risk of harm, such concerns should normally be communicated following the psychologist's work-place safeguarding protocol. Where this is not applicable, concerns about a child's welfare can be made directly to the local authority children's social care team.

Psychologists should:

- be alert to the heightened vulnerability/possible need for early intervention support for a child who: has a disability, has additional needs (including special educational needs), is a young carer, is showing signs of engaging in anti-social or criminal behaviour, has returned home from care and/or is showing early signs of abuse and/or neglect.
- be alert to heightened vulnerability where a child is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence.
- consider the potential impacts of parental/carer ill-health on the family and whether this creates any significant negative impacts or risks for children within that family;

- be aware that if an adult has responsibilities for children outside the home setting, such as working with children, their mental ill-health and/or their health more generally upon the adult's capacity to work safely;
- be aware that children within the same family can be treated differently (one child may be singled out for abuse);
- be aware/seek to understand how children can come to abuse other children;
- recognise that some professionals use their position to abuse children and vulnerable people; and
- challenge institutional abuse in its many forms.

Psychologists should be aware of situations of risk which require additional consideration, notably:

- sexual exploitation, which involves exploitative situations, contexts and relationships without the child recognising the harm on account of their age/understanding, social/economic and/or emotional vulnerability;
- internet abuse, which can involve cyber bullying, exposure to pornography or violence and exploitation of young people;
- domestic violence which may expose a child to violence directly or indirectly;
- shame-based abuse where children or young people may be physically assaulted or murdered because of bringing perceived 'shame' to their families or breaking cultural expectations of 'honour'; and
- Trafficking, any child transported for exploitative reasons is considered to be a trafficking victim, whether or not they have been forced or deceived. This is partly because it is not considered possible for children to give informed consent. Even when a child understands what has happened they may still appear to submit willingly to what they believe to be the will of their parents or accompanying adults.

Psychologists should have a knowledge and understanding of services for children in need and how to access them. Psychologists confronted with child abuse in any form should contribute to whatever actions are needed to safeguard children and promote their welfare. The needs/interests of adults should not be allowed to take precedence ahead of the needs of the child. Psychologists should work co-operatively with parents/carers unless this is inconsistent with ensuring the child's safety and ensure that the child's view is sought, heard and communicated. Psychologists should share appropriate information in a timely way, discuss any concerns and help analyse information so that an assessment can be made of the child's needs and circumstances. Psychologists should contact the children's services or social services department at the appropriate local authority (in some cases this role has been delegated to a multi-agency safeguarding hub) if they are concerned about a child or a vulnerable adult.

Managing cases of alleged historical abuse

There is a growing recognition that a disclosure of non-recent abuse may reveal current risks to others from an alleged perpetrator. Psychologists have a duty of care to their clients, and in the safeguarding of others. This may place psychologists in complex positions when trying to negotiate and balance their duties and responsibilities.

Psychologists who work with adult clients who disclose non-recent sexual abuse, should recognise that there may be current and ongoing risks posed by the alleged perpetrator to others. Not sharing concerns beyond the consulting room could mean that other children and young people could be at risk.

A client's allegations should be taken seriously, regardless of their presenting problems or mental health diagnosis.

Lack of access to children identified through familial relationships, work or volunteering roles should not eliminate concerns about risk, given opportunities for abuse to occur within communities.

It is crucial that psychologists seek advice from colleagues, particularly colleagues in safeguarding services, within the organisation and also from other agencies tasked with leading on safeguarding (i.e. social services). Psychologists working with clients without a referral and where no stakeholder agency is involved should seek advice from senior experienced colleagues on how to proceed. Psychologists need to be alert to the possibility that abuse may be organised, severe and complex.

There may be times when, in the interests of supporting a client's psychological readiness for disclosure, consultation may continue without requiring identifying details to be provided to the psychologist. It is important that a clients' lack of readiness to disclose does not become an obstacle to receiving psychological help. Further information is available in ***Society Document: Guidance document on the management of disclosures of non-recent (historic) child sexual abuse.***

Where the disclosure is made by the perpetrator of the abuse, risk assessment should be made regarding the context of the setting of the disclosure but there may be a professional obligation to disclose the criminal offence in order to safeguard other potential victims as above.

4.2 Safeguarding adults at risk of harm

The Care Act 2014 brought in new legislation regarding the safeguarding of all vulnerable adults. In some regions there is a move away from the term 'vulnerable adult' towards the concept of an adult at risk of harm.

An adult at risk of harm is a person aged 18 or over with need for care or support, who is experiencing, or is at risk of, abuse or neglect, and as a result of their needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The needs referred to here may cover a variety of personal or life circumstances including (but not limited to) cognitive impairment, age, disability, illness, injury or mental health condition.

The legal context

There is no set piece of legislation for adult safeguarding. It is a mix of criminal law, case law and welfare law. The Care Act 2014, updated in 2016, brought in the first legal framework for safeguarding adults in a single act. It contains a range of regulations and statutory guidance, which form the base upon how social care will develop in the future.

It enshrines the new statutory principle of wellbeing and it makes it the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. The act specifies the rights of those who need care and support, their carers, and the funding system for care and support. It recognises that this cannot be achieved by any single agency. Every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help to keep children and adults safe. Further information is available in ***Appendix 1: Relevant legislation.***

Modern slavery

An important area of concern is modern slavery. The Government website provides details about the government's work to end modern slavery, including details about how to refer victims into the national referral mechanism (NRM). Modern slavery is a serious crime. It encompasses slavery, servitude, and forced or compulsory labour and human trafficking. Modern slavery victims can often face more than one type of abuse and slavery, for example if they are sold to another trafficker and then forced into another form of exploitation.

A person is trafficked if they are brought to (or moved around) a country by others who threaten, frighten, hurt and force them to do work or other things they don't want to do.

A victim of slavery is entitled to help and protection from the UK Government (this is called the National Referral Mechanism), all support is provided on a confidential basis, and support to talk to the police. The National Referral Mechanism has been put in place to identify victims of trafficking and refer them to organisations that will offer help and support. Further information is available in ***Appendix 2: Websites and further information.***

Responding to concerns

Safeguarding adults means:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances and therefore potential risks to their safety and wellbeing.

Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers, and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

Care and support means different things in every case. The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they are aware of them.

The standard states that care or treatment must not:

- Discriminate on the grounds of any of the protected characteristics of the Equality Act 2010;
- Include acts intended to control or restrain an adult or a child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint;
- Be degrading to the adult or the child;
- Significantly disregard the needs of the adult or the child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority.

Safeguarding Adults Boards were established to help and safeguard adults with care and support needs The Safeguarding Adult Board must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies, according to the values of 'Making Safeguarding Personal' Guide 2014[37]. Making safeguarding personal is not just for people with capacity, it is just as important for people who lack capacity. The Guide specifies outcomes that people might want including to be and to feel safe, to maintain or get friends, to know that this won't happen to anyone else or to be able to protect self in the future.

The following are not outcomes:

- Harm or abuse is substantiated/unsubstantiated.
- The person is receiving increased monitoring or care.

The role of the Care Quality Commission[38] is to monitor, inspect and regulate services to make sure that they meet the fundamental standards of quality and care. The Commission works alongside Safeguarding Adults Boards and Safeguarding Children Boards to share information and intelligence where appropriate to help them identify risks. This includes providing appropriate advice and support to people at risk of radicalisation in sectors such as healthcare and education.

4.3 Terrorism and extremism

Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ('specified authorities' listed in Schedule 6 to the Act), in the exercise of their functions, to have 'due regard to the need to prevent people from being drawn into terrorism'. Depending on where the psychologist works, these duties may have relevance in the course of their employment. The term 'due regard' as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

The current UK definition of ‘terrorism’ is given in the Terrorism Act 2000. In summary, this defines terrorism as an action that endangers or causes serious violence to a person/ people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause. People suspected of being involved in such activity must be referred to the police.

‘Extremism’ is defined in the Prevent Strategy[39] as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty, and mutual respect and tolerance of different faiths and beliefs. Definitions of extremism can also include calls for the death of members of our armed forces, whether in this country or overseas.

While it is recognised there is no single profile associated with extremism, identity is considered to be central, and risk screening is based on assessment in relation to two general pathways into extremism – criminal and non-criminal. Disengagement follows a similar process. This is a contentious area of practice. Psychologists should ensure they focus on their core role, working in a non-stigmatising way, and avoiding profiling based on characteristics such as race, religion, ethnicity or any other aspect. The psychologist should carefully weigh relevant professional obligations and seek and follow appropriate local and employer guidance. Further information is available in ***Appendix 2: Websites and further information.***

5. Making and maintaining agreements

Both client and psychologist benefit by having arrangements for the work clearly set out from the start. Psychologists should be aware that all professional engagements are ultimately governed by the law of contract. A legally enforceable contract can arise as a result of the parties' entering into a written agreement, but can also arise as a result of a verbal agreement between the contracting parties.

A contract arises if the following are present:

- one of the parties (the offeror) had made an offer to the other party (the offeree);
- the offeree accepts the offeror's offer;
- there is consideration (i.e. something of value) passing from each party to the other, e.g. the offeror provide services to the offeree; the offeree pays the offeror;
- the parties intended to create a legal binding arrangement; and
- the terms of the contract are sufficiently certain.

While this does not mean that all client engagements are made subject to an agreed contract document, it does mean that in the worst-case scenario of a complaint against a psychologist being made, it will be very helpful for the psychologist to be able to demonstrate that they have met their professional obligations to their client. This will be best done by demonstrating that an agreement was made by both parties who knew what they were agreeing to, that the parties had the legal capacity to make such an agreement and that what they were agreeing to is permitted under the law. Where the client does not have the capacity, best interest decisions need to be made in accordance with the Mental Capacity Act. Further information is available in ***Section 6: Obtaining informed consent.***

Psychologists may wish to include the following when making agreements:

- the role and function of the psychologist;
- the psychologist's relevant qualifications, areas of expertise and ways of working;
- relevant limitations of the psychologist's practice, e.g. assessments not accepted or types of activity not undertaken;
- where the psychologist is appointed to work with a third party, the psychologist should make clear their obligations to each of the clients concerned and each client's obligations under the agreement and ensure that there are no conflicts or ambiguities;
- the extent of the psychologist's power and responsibilities when acting on behalf of other agencies;
- obligations in relation to duty of care and safeguarding, and related limitations to confidentiality;
- how confidentiality of client information and data is assured and any limitations to that confidentiality;
- how conflicts of interest will be managed if applicable;
- the client's, or other party's, rights of access to stored information;
- the use of any one-way viewing screens or video or audio recording and the security of any recorded material;

- the nature of psychological activities involved, the reasons for undertaking them and information about the likely outcomes;
- the availability of the psychologist to the client;
- details of fees, together with application of VAT if non-clinical services, or expenses to be billed in connection with the work undertaken;
- what is expected from the client as their contribution to the engagement with the psychologist, expectations for payment and consequences of non-payment;
- ownership of intellectual property rights;
- what might cause a breach of the agreement;
- the rights of each party to withdraw from the agreement and the consequences to any financial agreement;
- recourse to dispute resolution or law;
- the equality and justice aspects of social policies and their possible impact;
- external ethical scrutiny and approval of the engagement, where appropriate; and
- arrangements to terminate the retainer.

In advance of any psychological assessment, the client should be made aware of the availability of services, and the existence of any waiting lists for intervention.

For some approaches, intervention follows an evolving path, unique to each client and his or her life circumstances, which cannot be precisely predicted in advance. Clients should be made aware of this uncertainty, and predictions should be made on the best judgments. It is recognised that it is sometimes unrealistic and undesirable to provide detailed information on all aspects of psychological intervention, and consent should be obtained to a general strategy rather than specific procedures. Further information is available in this document or the ***Society Website: http://beta.bps.org.uk/Practice-Guidelines.***

5.1 The practitioner’s right to withdraw their service

There are circumstances in which a psychologist may decide to terminate the agreement for provision of psychological services. The circumstances may be personal or professional.

The personal circumstances may include but will not be restricted to leaving employment in a psychological service, incidences of illness or family commitments.

The professional issues may relate to service structural changes, safety, or provision of most appropriate service.

In these circumstances, psychologists will, as far as possible, work to ease the transition of service provision and give as much notice as is practical in the particular situation.

5.2 Referrals

Where a psychologist finds themselves unable to come to an agreement with a client, the psychologist may refer the client to a suitably qualified colleague. Psychologists will both make and receive referrals when working in services with other professionals.

In making referrals, psychologists should consider the needs of the client and to the best of their knowledge refer to another professional with the appropriate skills and experience.

In receiving referrals, the psychologist should consider whether the referral is appropriate for psychology, establish the client's understanding of the purpose of the referral, and consider as far as possible prior to meeting the client whether the referral falls appropriately within their own areas of practice.

5.3 Representation of the qualifications and status of the psychologist

HCPC registration and BPS Chartered Status

Psychologists are encouraged to state their registration with the HCPC and protected title(s). This will provide assurance that the psychologist meets national standards of training and professional skills.

Use of the 'consultant' title

The term 'consultant' generally does not have a formal definition. Within the medical field it is used by doctors who have considerable experience and proven expertise demonstrated through examination within their respective Royal Colleges.

While there is no clear comparable grading structure for psychologists outside the NHS (within the NHS, the consultant title is used by psychologists who are employed in Band 8C, 8D and 9 positions), the use of this title would be seen to reflect both seniority and specialist expertise.

There is a difference between a 'consultant' psychologist and a psychologist who provides consultations in their context of practice. The Society expects that psychologists should be honest and accurate in representing their professional affiliations and qualifications, including such matters as knowledge, skill, training, education and experience.

The Society's position is that this would be applicable in any situation where expert knowledge or skills is being marketed or promoted, whether or not this is for financial gain. Further information is available in ***Society Document: Guidance on the use of the title 'Consultant Psychologist'.***

6. Obtaining informed consent

Psychologists should always ensure that they have sought and received the consent of those they work with, given of their own free will, without undue influence.

The concept of informed consent relates to the client's right to choose whether to receive psychological services, and to make this choice on the basis of the best information available presented in the most appropriate way. The principles apply, whether the psychologist works in the public, private or voluntary sector or in independent practice.

Psychologists should obtain the informed consent of the client in an appropriate manner prior to undertaking any assessment, intervention or research activities. In all circumstances, common sense and ethical practice should apply when considering the approach to gaining informed consent from those with whom the psychologist is working.

This section refers, in the main, to consent with adults with capacity. Further information on informed consent with discrete communities where further consideration may be needed is available in ***Sections 6.1 to 6.4***.

Obtaining informed consent involves a process which is dynamic and is relevant to the specific assessment, intervention or decision being made at that time. When there are substantive changes in the intervention or when the psychologist has reason to consider the client may no longer consent, consent should be reviewed. Psychologists should ensure that their clients are enabled to play an active role in this process. Clients should be encouraged to ask questions whenever they are in doubt.

Psychologists should be aware that a client's desire for help, and the immediate impact of the psychologist's supportive listening, may affect the client's ability to make informed choices about the help they wish to receive. They should also be aware that their own desires to help a client may bias their presentation of information, such as the probability of successful outcomes.

Psychologists should be aware of the complexities of obtaining informed consent to treatment due to the perceived power, status and authority of the professional psychologist. It may not be clear if the consent given is freely given by the client or, for example, is part of a pattern of compliance towards authority figures. Equally, a client may say that they understand the explanation given by the psychologist, and accept a plan for intervention, in order to avoid the discomfort of being seen not to understand the psychologist's complex language and ideas.

Obtaining informed consent is particularly difficult when the client is obliged to undertake the psychological intervention as part of an employment process or performance measure where they may have obligations under their employment contract; or when detained.

There should ideally be an ongoing dialogue between client and psychologist, as part of the process of joint decision-making. At any point, the client should feel free to ask questions about the impact of the treatment and withdraw consent to continue.

Psychologists should attempt to intervene against the express wish of a client only after careful consideration and in line with relevant legislation, policies and professional practice.

Provision of information for informed consent

In order to ensure that the client has all the information necessary to make an informed decision about whether to take part or not in a psychological activity, they must be provided with relevant information, such as that listed below, in a format that is designed to meet their specific needs.

The psychologist should consider providing information about the following:

- what the psychological activity involves, as far as this is consistent with the model of interaction, e.g. there will be limits in the use of some non-directive therapies and psychometric assessments;
- the benefits of the activity, either directly to the client in the case of assessment or intervention, or indirectly in the case of systemic intervention, or to potential theoretical advances or service improvement;
- any alternative assessment or treatment options and their known availability;
- foreseeable risks and how minor or serious they may be, for example the potential to feel worse at stages during therapeutic interventions;
- what might be the benefits and potential costs and risks to them of engaging or not engaging in the proposed psychological activity; and
- the client's right to withdraw their consent from assessment, treatment or intervention at any stage, along with information about any likely consequences of such withdrawal.

Consent to involvement of others

Psychologists have an obligation to ensure that prospective clients are informed of the extent and limitations of confidentiality with respect to anticipated services, the purposes of any assessment, the nature of the procedures to be employed or the intended uses of any product such as notes or recordings, before the assessment or intervention starts. Further information is available in ***Section 7: Managing data and confidentiality.***

The psychologist should ask the prospective client: whom they would wish to be informed of their assessment or treatment, if anyone; and the information they are willing to share where communication is essential, for example to the referring agent or organisation, management or court. Wherever appropriate, including in the law, the client should have copies of reports or letters or be given feedback so that they are kept fully informed.

If it is deemed necessary to move from individual contact to include others this should where possible be done with the client's prior consent.

Psychologists may be asked to provide consultancy or advice to colleagues about an identified client, without that person's knowledge or when the client has indicated that they do not want to have direct contact with the psychologist. In these circumstances, the psychologist will need to consider their potential involvement and the need for consent.

A psychologist who draws upon the work of other professionals in preparing a report, should seek their consent, where possible and if not already in disclosed records, to include that material and should acknowledge its source in the report.

If a report is requested which draws upon previous or concurrent investigations of a client in other contexts, for example NHS records in the preparation of a report for the court, the client's consent or relevant authority's consent for that information to be used should be sought.

If psychologists wish to use reports on clients which have been compiled by other professionals, they should do so only with the consent of those professionals and use the reports only in the context for which the report was specifically provided.

Information on and consent to record-keeping

Express consent must be sought in advance for the use of video, audio recording or one-way screens, with a clear explanation of the purpose of these. Further information is available in ***Section 7.1: Information governance***

6.1 Informed consent for court

When a psychologist is instructed to give evidence in court, it is the court that should be informed and whose authority should be sought for the work undertaken. When serving as a witness in the legal arena, the psychologist is responsible to the court, rather than to either party.

6.2 Informed consent with children and young people

All children and young people, whatever their age or status, have a right to express their views freely and be involved in any decision-making that affects their lives, which includes judicial and administrative proceedings[40]. Therefore, psychologists who seek to work with children or young people must gain their informed consent. This applies whether the child or young person or another agent with legitimate responsibility for the child or young person has made the request for involvement. Any direction or guidance provided by parents or other caregivers must be 'in accordance with the child's evolving capabilities' and support the 'exercise by the child of his or her rights'[41]. The onus is then on the adults to provide appropriate support to enable the child or young person to express their views and contribute to decision-making.

Every psychologist should consider how they can:

- provide an accessible explanation to the child or young person about their work as a psychologist;
- offer a clear reason for their possible involvement;
- provide an opportunity for the child or young person to talk about what working with the psychologist might involve.
- discuss and agree how information is recorded and possibly shared with others with an awareness that young people who are 'Gillick competent' can consent to information not being shared with parents;

- discuss how the child or young person will be kept safe;
- ensure that the child or young person has understood the psychologist's role and has given their informed consent;
- ensure the child or young person understands they can withdraw their consent at any point;
- ensure their practice acknowledges and respects the culture, community and context of the child or young person.

Occasionally, a disagreement over consent may arise between parent/carer and child or young person and/or between parents/carers. The psychologist would make every effort to resolve the difference of views, perhaps seeking, with agreement, involvement of an appropriate family member and/or a colleague, although as discussed above, a young person who is 'Gillick competent' can legitimately request that family members (including parents) are not involved or informed of any involvement. If the disagreement is not resolved, the psychologist should draw on their professional experience to act in the best interest of the child or young person seeking consultation and support through appropriate channels, including safeguarding and legal departments, and consultation with appropriate colleagues including other professionals.

6.3 Informed consent with people who may lack capacity

It is likely that psychologists at some stage within their careers will be working with people who lack capacity to consent to assessment or treatment. This could be because of a wide range of difficulties such as intellectual disability, brain injury, dementia, severe mental health difficulties, and neurological conditions. As a result, it will often be necessary to make a judgment about a client's ability to give informed consent. This should include whether the person is able to:

- understand the information relevant to the decision (e.g. psychological treatment);
- retain that information;
- use or weigh that information as part of the process of making the decision; and
- communicate their decision (whether by talking, using sign language or any other means.)

The Mental Capacity Act 2005 contains 5 key principles which it is important to understand:

1. A presumption of capacity;
2. Individuals being supported to make their own decisions;
3. Individuals have the right to make 'unwise' decisions;
4. Anything done on behalf of a person with a mental capacity issue should be in their best interests; and
5. An intervention should be on the basis of the 'less restrictive option' weighed up in the particular circumstances of the case.

The Mental Capacity Act Code of Practice[42] expands upon these points (and indeed all aspects of the Act), highlighting the need to assist a client in making a decision for themselves (with the use, for example, of memory aids, simplified resources, etc.). It should also be noted that the fact that a person is able to retain the information relevant to a decision for a short period does not prevent them from being regarded as able to make the decision.

The Mental Capacity Act (2005) provides a clear framework for what to do if a person lacks capacity to make a range of decisions, including consenting to treatment. The principle of 'best interest' must be followed, and the Act states clearly who needs to be consulted in relation to making such a decision and ensuring that the individual's wishes are considered.

It is good practice to give full information (possibly using adapted resources) to clients even when they are not deemed able to give informed consent. The psychologist must, so far as reasonably practicable, permit and encourage the client to participate, or to improve their clients' ability to participate, as fully as possible in any act done for the client and in any decision affecting them.

In some circumstances, it is possible that there may be others who have been given legal authority for decision-making on behalf of others, such as Power of Attorney for Health and Welfare or Deputyships for Health and Welfare. It is important to note that patients might also have created Property and Affairs Lasting Powers of Attorney. Those acting under a Property and Affairs power alone will not have authority to make decisions in relation to a patient's treatment. If someone is a Health and Welfare Attorney or Deputy, those persons will be able to make those decisions on behalf of others. It is also necessary to ensure that the client has not made an Advance Decision to refuse treatment prior to the loss of capacity, although this is unusual in relation to psychological treatment.

In some clinical contexts, particularly relating to brain injury, intellectual disabilities and dementia, issues related to capacity and best interest are particularly prevalent. Psychologists practising in these areas need to ensure sufficient knowledge and expertise. Further information is available in ***Society Document: Guidance on determining the best interests of adults who lack the capacity to make a decision for themselves.***

6.4 Informed consent with people as employees

Tripartite arrangements where an employer commissions and pays for an assessment or intervention, such as diagnostic assessments for neurodiversity and cognitive functioning return to work assessments, or coaching, potentially give the employer access to data that they will struggle to interpret, or may misinterpret, for example test scores and details of personal life. It is important that the psychologist protects the employee by giving the employer only what they need to know and can reasonably require for the purpose of employment.

The Psychologist should consider whether they will be gathering information that is not usually held by an employer, or is not held routinely for all employees, for example IQ scores and childhood experiences. If so, the psychologist should consider abridging documentation so that the employer receives only the information they 'need to know', and the employee can if necessary hold a full copy for future reference. This prevents discrimination against employees who are subject to in depth assessment for reasons related to illness, neurodiversity or disability from being unfairly compared to their peers. It also prevents complex psychological information from being held by those who are not qualified to interpret it.

Agreements should be made explicitly about the information which can be shared with the commissioning organisation. In order to aid transparency, information should normally be sent to the client prior to being shared with the organisation.

6.5 Informed consent with detained persons

Prisoners

Informed consent may be harder to obtain when a client is detained. Psychologists working with detained persons should be aware that, as well as UK law, the UK is signatory to a number of conventions on the treatment of detained persons. These conventions not only outlaw physical ill-treatment, but also certain kinds of psychological pressure. For example, it is contrary to the UN Convention on Torture to apply psychological pressure to elicit a confession, or compliance with a regime. In this context, 'psychological pressure' could include making progression contingent on compliance with a particular aspect of the regime. Practitioners should be particularly mindful of the power imbalance in forensic contexts, which is far more acute than is generally found in non-justice system based settings. Only offenders detained in secure hospitals can be required to comply with assessments or treatments under involuntary detention sections of the Mental Health Act.

Mental Health Detentions

For psychologists there can be potential conflicts of interest or what could be better termed 'competing duties of care' between the roles of Responsible Clinician (RC) (for further information on this role see Section 3.5) (including the duty to detain or otherwise compel participation in treatment) and that of psychologist (including, principally, the duty to establish freely-given consent wherever possible to enhance the efficacy of the therapeutic intervention). The MHA Code at chapter 24.34 (medical treatment) states that permission given by a patient to a particular treatment 'under any unfair or undue pressure' is not consent (p.257).

Good outcomes for psychological therapies are associated with positive therapeutic alliances and good working relationships between therapists and patients. The potential for even perceived abuse of power and the inherent power differential between an RC and a detained patient subject to the MHA runs a risk of rupturing this relationship or it becoming coercive. Psychologist RCs must therefore remain aware of and give full consideration to any potential competing duties of care between the RC and psychological therapist roles when providing psychological treatments to patients over whom they have compulsory powers.

The main issues to be considered by psychologist RCs when addressing potential competing duties of care in this context include the following:

1. Psychological treatments (with the possible exception of indirect interventions delivered by proxies such as paid staff and carers) are more likely to be effective when informed consent is obtained. As such, RCs acting as psychological therapists should utilise all reasonable and ethical attempts to obtain consent from patients before proceeding with psychological treatment. The *Code* at chapter 24.34–24.39 (p.257) provides guidance on obtaining consent.
2. The Act permits psychological treatment to be given without consent and the Code provides guidance on how to proceed with treatment in these circumstances (chapter 24.40–24.44, pp.257–258). There may be circumstances, especially when significant risks to others or self have been identified, when it is considered to be necessary for a psychologist RC to proceed with providing psychological treatment without consent. In such circumstances then there should be, where practicable, prior discussion with the MDT involved in the patient's treatment and care about the risks involved. Careful consideration should be given to the availability and merits of another suitably qualified member of the team providing the psychological treatment required with the RC remaining in overall charge of the client's care.
3. There may be situations where it is judged that informed consent cannot be clearly obtained, or where it would appear another available practitioner would be more likely to achieve a more effective outcome (perhaps due to the power differential between patient and RC). In such situations the psychologist RC is advised to refer on to other members of the treatment team who are able to provide the psychological treatment needed, while the RC remains in charge of overall care.

7. Managing data and confidentiality

7.1 Information governance

Psychologists should follow local and national guidance and statutory responsibilities regarding management of data. Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by/working in collaboration with. Further information is available in ***Section 1.1: Legal and professional obligations of psychologists, Appendix 1: Relevant legislation*** and ***Appendix 2: Websites and further information.***

Psychologists must bear in mind the potential impact of the information in their records on all who may have access to such records, for example, the client, other professionals, managers, authorised carers, etc. Where possible, distinction should be made between fact, observation and opinion, and judgemental comments should be avoided. Psychologists are responsible for holding their records securely to ensure the confidentiality of the information contained within them and to control access to them. Further information is available in ***Society Guidance: Guidelines on the use of Electronic Health Records.***

This guidance applies to all record-keeping on clients, their relatives, carers and/or associates, and their organisations, regardless of the media in which information is held, e.g. written notes and reports, audio- and video-recordings, paper and electronic records, etc.

Records made, kept or accessed by psychologists should be:
- systematic and appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

Clients have a legal right to access records concerning them, and this right is enshrined in legislation. Additionally, it is good practice for clients to be given feedback on their content. Sharing records with clients supports the collaborative approach of psychologists and enables clients to have full and effective involvement. Client access to records will be restricted to information about themselves and not third parties. Restrictions will also apply when disclosure would place the clients or others at risk of serious harm.

In tripartite arrangements involving an employer access to information should be governed by agreements made explicitly about the information which can be shared with the commissioning organisation.

Shared records

In some organisations in which psychologists work single, multi-professional, client-based records are held. Such records are designed as shared documents (paper or electronic), the function of which is primarily to facilitate inter-professional communication to ensure the safe and effective delivery of high quality services. Such records may be shared among organisations/agencies to facilitate care and/or exceptionally, to safeguard the client or others, including the general public. In some contexts, clients have the right to object to their data being disclosed to a third party even someone who might provide essential healthcare. Psychologists should be aware of local codes and policies. Further information is available in ***Section 3.5: Working with other professionals***, ***Section 7: Managing data and confidentiality*** and ***Appendix 2: Websites and further information.***

Psychologists should include in the shared record all information about their work with clients and related others which is required to ensure appropriate multi-professional care and to safeguard the client and relevant others, including the general public.

Third-party and sensitive material should be clearly marked. There should be clarity/clear communication within the multi-professional team about what is and is not shared with the client if there are safeguarding concerns. A system needs to be established about how suspicions and causes of concern are recorded and/or shared.

Where shared records are held, other professionals involved with the clients will have access to such records. This should be explained to the clients at the onset of engagement with them.

The use of sealed envelopes is no longer considered good practice following the findings from serious untoward incident investigations where the existence of sealed envelopes compromised care.

Assessment materials

Psychologists should be mindful at all times of the confidential nature of assessment materials. Many assessment measures are invalidated by prior knowledge of their specific content and objectives. Psychologists who use these materials are required to respect their confidentiality and to avoid their release into the public domain (unless this is explicitly allowed in the nature of the instrument and by the test publisher). Psychologists should, therefore, take reasonable steps to prevent misuse of test data and materials by others. Further information is available from ***Appendix 2: Websites and further information.***

In many organisations, there is only one shared records system. In these cases, it is necessary for psychologists to be able to use the shared records system to hold raw data from psychometric assessment. The results of psychometric assessment will be incorporated into reports which explain their context and appropriate interpretation, and which are included in the shared institutional record. In relation to the visibility of the psychometric instrument and the raw data to other members of the multidisciplinary team who are not psychologists, the onus is on the other professionals not to interpret information where they are unqualified to do so, just as the psychologist would not interpret, for example, physical healthcare test results they are unqualified to interpret. Psychologists may consider whether it is appropriate to mark assessment materials so their nature is clear.

Additional data

Psychologists may wish to keep separate notes to aid their work but which are not intended for sharing with others or to be part of the permanent client record. These notes, often called process notes, which are written for the purposes of reflection on practice, should be anonymised with no other identifying links e.g. initials, appointment time, so that these notes therefore are clearly not part of the client record. Process notes may, for example, be used for reflection and supervision. If process notes are made to assist in compilation of a report, the material should be incorporated, as relevant, into the final report and the process notes then destroyed.

Long-term illness, incapacity or death of a psychologist

Most organisations will have procedures in place in the event of illness, incapacity or death of a psychologist. Psychologists in independent practice are advised to make a professional will and to appoint a professional executor, probably an experienced colleague, whose role it would be to take charge of client records, to inform the clients involved and, where appropriate and practicable, to make provision for continuity of the service provided.

Retention and destruction of records

Psychologists' records should be held securely for as long as they are required for the purpose of psychological work. Psychologists must follow legal requirements, national and local policy frameworks and procedures regarding the retention or disposal of records after the psychologist's work is concluded. Psychologists should ensure that they keep up to date with requirements.

For independent practitioners general guidance is that many independent psychologists keep records relating to contact with adults for 7 years, and follow NHS guidance in relation to children. Where the records derive from work undertaken within an organisation, the maintenance of these records is determined by the organisation's policies and legal requirements.

Retention and destruction of health records, both paper and electronic, is covered in the NHS code of practice for records management. Generally speaking, retention is until age 26 for people seen as children; 20 years after the last contact for adults, and 8 years after death if the death occurred while the person was in the care of the NHS. There are specific requirements for mental health services depending on the nature of the contact.

In education settings, Local authorities generally retain Education Health and Care Plans for 35 years after the case has been closed. Other records are retained until the child is 25.

All records must be destroyed under confidential conditions following organisational procedures or for independent practitioners using a destruction service or process which meets industry standards for document management and can provide the appropriate certification.

7.2 Confidentiality

Clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential. Psychologists have a duty not to disclose such information except as discussed below and to bring their confidentiality practice to the attention of their clients, employers, managers and any other professionals involved.

Psychologists have a duty to inform involved parties of their confidentiality standards and practice at the point of first contact. Clients should be informed of the limits of confidentiality where information about them may be shared and confidentiality breached, for example for reasons of safeguarding, requirements of the law, and public protection.

Psychologists have a duty to be aware of the content of any other relevant guidelines and of any other policy guidelines which set out local expectations.

Use of client data for audit must follow the Caldicott principles, which, designed for the NHS, provide helpful guidance for any setting in terms of when it is appropriate to use with client-identifiable data and when anonymised data should be used[43]. Generally under data protection legislation, it is necessary to obtain specific informed consent for the use of client data for particular purposes, and to inform clients of the purposes for which their data is being collected and how it will be used. Further information is available in ***Appendix 2: Websites and further information.***

Disclosure of information

If disclosure of information is deemed necessary, psychologists should obtain specific informed consent from their clients, making the consequences of disclosure as clear and unbiased as possible. There are a number of circumstances where this might not be possible or may not apply: for example where the health, safety, security or welfare of the client or someone else may otherwise be put at risk; and if there are legal or safeguarding responsibilities, such as the need to avoid ‘tipping off’. If confidentiality is broken without consent, the client should be told what has been said and to whom, unless such disclosure may expose the client or others to serious harm or is contrary to legal or safeguarding obligations.

Psychologists who are faced with the difficult decision as to whether to disclose information without a client’s consent must weigh carefully the arguments for and against disclosure. The responsibility for this decision lies with the individual psychologist although they may seek advice and guidance from appropriate sources such as their employing organisation’s Information Governance or Data Protection Lead, Clinical Governance Lead, Caldicott Guardian, Safeguarding named and designated professionals, or legal departments. These other professionals can be the most helpful sources of advice in difficult disclosure situations. Independent practitioners may wish to consult the legal helpline of their professional indemnity insurer.

Circumstances may emerge where clients may present a risk to others or to themselves, or be at risk from others whom they wish to protect. It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients, and to employers if a client’s mental health status presents a risk to others via driving, handling machinery or interaction in a working situation, for example, flight deck crew. Disclosure without consent, or against the client’s expressed wish may be necessary in situations in which failure to disclose appropriate information would expose the client, or someone else, to a risk of serious harm (including physical or sexual abuse) or death.

The psychologist must weigh up the needs and interests of their own client against the wider welfare, protection and safeguarding of the public.

Disclosure to clients' employers, insurance companies and others

Psychologists have a duty to ensure, at first contact, that clients understand the purpose of any assessment undertaken at the request of employers, the DVLA or insurance companies, and of the psychologist's obligation to disclose the results of that assessment. In the case of assessment for fitness to work or to drive, they should obtain the client's written consent.

Psychologists should consider what each party involved needs to know, gaining understanding and agreement on which aspects will be fed back, in advance. For example, the full detailed and raw scores obtained by a psychologist in recruitment assessment processes may be unsuitable for an employer to receive in full. The commissioning body should be made aware of the decision-making data that they originally requested, in the case of an employer this could include strengths and weaknesses, and recommendations for employer actions, for example.

Primary clients should be advised about and able to preview, with opportunity to ask questions first, any data that will be sent to an employer about them. Bear in mind that the informed consent difficulties still stand and that an employee or potential employee can withdraw consent for the employer to be informed of any part of their results.

This can be very difficult to manage in practice, and requires psychologists to make these agreements with their commissioners before they start the work, so that all are informed of the risks in the service delivery. Further information is available in ***Section 3.4: Working with multiple clients.***

Disclosure after a client's death

After a client's death, relatives or other authorities may seek access to the psychologist's records. In the first instance, the psychologist is advised to follow organisational procedures where they exist which usually deal with the administrative proofs required such as proof of death, proof of kinship and right to access the material requested.

A psychologist's duty of confidentiality continues after a client has died. The psychologist will need to weigh up the circumstances around the request for disclosure and what personal information is being sought. If there has been a specific request by the client for their information to remain confidential, their wishes should usually be respected. If the psychologist is unaware of any instructions from the client, when considering requests for information the following should be taken into account:

- the purpose of the disclosure;
- whether the disclosure of information is likely to cause distress to, or be of benefit to, the client's partner or families;
- the permission of a surviving relative or next of kin is not required, and does not authorise disclosure of confidential information, although the views of those who were close to the client may help the psychologist decide if disclosure is appropriate;

- whether the disclosure will also disclose information about the client's family or anyone else; and
- whether the information is already public knowledge or can be anonymised or coded.

There may be circumstances where the disclosure of information is required, for example:
- to support an inquest or fatal accident inquiry;
- where the disclosure is required by law, is authorised under section 251 of the NHS Act 2006, or is justified in the public interest, such as for education or research;
- in the case of national confidential inquiries or for local clinical audit; and
- when a person has a right of access to records under the Access to Health Records Act 1990 or Access to Health Records (Northern Ireland) Order 1993.

7.3 Confidentiality when safeguarding

In exceptional circumstances it may be necessary to breach the client's confidentiality with or without their immediate knowledge or consent. This would be the case where there are significant risks to the client's psychological wellbeing; where the alleged perpetrator may be a current risk to others or where there is risk of jeopardising a potential investigation. Any decision to breach confidentiality cannot be taken lightly, but can be justified and accounted for if made in good faith because of safeguarding concerns. This is supported by professional guidance. The focus of any intervention including any breach of confidentiality must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the client's capacity to consent, their choices and preferred outcome for their own life circumstances.

Specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support. When considering sharing personal information, the specified authority should take account of the following:
- necessity and proportionality: personal information should be shared only where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of the power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998; and
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

In relation to health sector staff, government guidance states it is important that staff understand how to balance client confidentiality with the duty to report. They should also be made aware of the information-sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

7.4 Confidentiality for the court

Psychologists acting as expert or professional witnesses have a duty to disclose all of the evidence used to reach their opinion where directed by the court to do so.

This could include:
- the details of any tests and assessments administered with professional colleagues;
- notes made during report writing; and
- referenced academic articles or studies.

No information relating to an assessment or report should be disclosed outside the relevant proceedings without agreement. Psychologists should normally seek permission from the instructing party to disclose any information to another health care professional.

Where instructed directly by the court, the Crown Prosecution Service, Procurator Fiscal or a solicitor, the psychologist is required to report or comment on any or all aspects of the case that appear to the psychologist, as an expert in the field, to be relevant or pertinent. In such circumstances, the psychologist is not in a position to offer confidentiality to any person, and should make this position clear to any party with whom they have contact during psychological investigations or assessment.

In these circumstances, it will be important that the psychologist makes sure they are up to date with the legislation and policy guidance regarding public and media access to information available to whichever court or tribunal their instruction arises from. The psychologist will need this awareness so that they can explain to the adult or child concerned what the limits of privacy are in these legal circumstances. They will need to make clear to the client which information needs to be made accessible, by whom and under what circumstances. Only when the client understands this, can they give informed consent.

There are different levels of access to sensitive information in different legal contexts; this will include testimony, documents and professional and expert reports. Many proceedings typically take place in open court, to which the public has access. In these cases, there is a presumption in favour of providing information and documents to third parties which were relied upon by the court in reaching its decision, though not the entire court file.

Where court papers and other materials are received in electronic format, psychologists should ensure that these are stored in a secure, password-protected format. This may require the addition of additional security for documents that arrive in an unsecured form. Where psychologists submit reports in an electronic format they should ensure that these are in a secure, password-protected format.

Psychologists working with clients who are the subject of court proceedings may need to be careful to ensure that they keep all records which may be of relevance to the court process until it is clear that the court has reached a final conclusion, including any appeal that may have been heard.

With few exceptions, applications in the family court are heard in private, with only those immediately involved being allowed to attend and access information. It is possible, however, for duly accredited members of the media to attend hearings in the family court, subject to the power to exclude them on specified grounds.

In most family court proceedings, media representatives have no entitlement to receive or peruse court documents referred to in the course of evidence, submissions or judgment. If media representatives wish to see documents referred to in the family court they may apply to the judge for disclosure but they are subject to strict guidance in terms of what information they can divulge into the public domain.

7.5 Confidentiality with children and young people

When beginning direct work with a child or young person, the psychologist should discuss and agree who will have access to the information arising from the work, with direct reference to principles of 'Gillick competence'. In undertaking this discussion it is helpful to acknowledge that there may be those adults (e.g. parents/carers, other relevant professionals such as teachers, social workers, counsellors) who may have a supportive interest in the work and may wish to have appropriate access to information but the wishes of a 'Gillick competent' young person should take precedence unless there are safeguarding concerns.

Parents or those with legal responsibility may be made aware of this agreement if appropriate, although a young person deemed to be Gillick competent is able to agree to work with a psychologist independently. Those with parental responsibility do not have an automatic right of access to the psychologist's records by making a subject access request under data protection legislation.

The nature and purposes of any work will vary and this will determine how and to whom information will be shared, however the child or young person should always be made aware of who will have access to what and for what purpose and due consideration given to the wishes of a 'Gillick competent' young person about who can have access to information about any involvement with a psychologist. The child or young person should be fully aware of the content of any shared information, including as appropriate, copies of the documents. Whatever is agreed about information sharing including work where information is confidential, the psychologist must ensure the child or young person knows and understands that if there is a risk of harm the psychologist must follow safeguarding procedures.

7.6 Confidentiality with detained persons

When detained persons give informed consent to the collection of information, they do so for a specific purpose and for use by specific people. The use of such information for a different purpose or for use by different people would require separate consent. Thus, although a psychologist may interview and write a report on a detained person, consent for that purpose cannot be taken as allowing a third party access to the psychologist's records on that person, such as notes on (or recordings of) the interview. If psychologists are put under pressure to reveal such information, they should seek the advice of colleagues including for example those responsible for governance or data protection. They should bear in mind that they have a legal duty to be aware of and comply with data protection legislation and professional confidentiality rules.

7.7 Confidentiality obligations during training

During training, no academic/training documents should identify clients to whom they relate (even by means for example of initials, service name or date of appointment) as any such potential identifiers could be used to trace the client and therefore make the document a part of the clinical record and subject to the relevant provisions of data protection legislation. This includes published reports, case studies prepared for trainee assessments and any articles or publications. Tutors and supervisors should communicate this to their trainees. Trainees should be clearly instructed to both make and keep separately those records which are part of the provision of psychological service and which belong to the service organisation and are subject to its policies and procedures; and papers which are anonymised and are part of the trainee's academic learning, and belong to the trainee and are subject to the training provider's policies and procedures.

Express consent should be obtained by trainees before audio- or video-recording their interactions with clients. If the client is unable to give informed consent, it is unlikely to be appropriate for the recording to be made. Careful consideration should be given before any material is recorded if the client is party to any legal proceedings or family or employment disputes. If material is to be used for purposes other than client care (including teaching and research), the client should be informed of the purposes of the recording. It should be made clear to clients how the material will be used and to whom it will be disclosed, for example, trainee students, other researchers, and supervisors.

The trainee and the client should come to an agreement about how long recorded material should be kept. The general principle is that recordings will be kept for as long as needed to fulfil the purpose for which the client has given consent and no longer. The security of the material must be maintained, and it must be destroyed at the agreed time limit if no longer required.

Informed consent is required before client material in an identifiable format may be published in case studies, presentations or other research reports. It is becoming common practice for clinical material in professional doctorate portfolios to be stripped out before the thesis is placed in online institutional repositories.

8. How to respond when things go wrong

8.1 Managing conflict with a client

Conflict with a client suggests that someone's expectations are not being met. The first objective should be to restore agreement or agree to make changes. The well prepared psychologist will have a client agreement in place and will be able to review the experience against the agreement with the client to address this question. Further information is available in ***Section 5: Making and maintaining agreements.*** Even in the absence of an agreement, the psychologist would be advised to enquire with the client where their expectations are unmet or raise their own unmet expectations with the client. This can be an opportunity to put a belated agreement in place.

It may be that the parties agree to set aside the agreement and bring it to an early close. Agreeing to disagree may be a better outcome for psychologist and client who cannot restore agreement. Take account of any need for onward referral either within the service or elsewhere or back to the original referrer, and depending on the nature of the work setting, any financial obligations in closing the work.

The psychologist may find it helpful to consult with appropriate colleagues in preparation for the conversations with the client, such as line or service managers, those with other relevant organisational responsibilities, and supervisors. There may be more general lessons to be drawn as part of reflective practice in relation to the quality of the client agreement for future use.

8.2 Transparency and duty of candour

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 duty of candour (regulation 20) requires all health and adult social care providers registered with the Care Quality Commission to be open with people when things go wrong. Psychologists need to be aware of the terminology relating to this regulation including:

- openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered;
- transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators; and
- candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Psychologists also have a responsibility to ensure that they engage in open and transparent communications with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. Guidance from the Care Quality Commission on duty of candour outlines the specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information, and making an apology. Psychologists are instrumental in supporting organisations to promote a culture that encourages candour, openness and honesty at all levels. Further information is available in ***Appendix 2: Websites and further information.***

8.3 Managing conflict in team settings

Dealing with breakdowns in working relationships, professional disagreements and fitness to practise concerns

As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues (including relating to consultation/supervision or line management) by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

Where there is serious or continual disagreement, both parties need to take whatever action is appropriate in their professional context, consulting other experienced professionals as necessary.

Supervisors and line managers have professional obligations concerning professional standards, ethical practice and 'fitness to practise' issues. If line managers or supervisors have any concerns regarding performance in these areas, they have a duty to discuss these with the psychologist and, if necessary, address the matters by in the first instance following appropriate employment policies and procedures, or in the case of an independent practitioner, making a report to the HCPC.

Working in multi-professional or multi-agency contexts

Psychologists may find themselves in conflict with the approaches to work taken by other individual colleagues or by the multi-professional team or agency.

Psychologists should bring to the awareness of the multi-professional team or agency any difficulty in the group working together which may impact on the psychologist's ability to function effectively and ethically in their role. Such issues are best addressed when guided by national and local policy and current legislation before proceeding with multi-professional/multi-agency collaboration. Further information is available in ***Appendix 1: Relevant legislation.***

The psychologist may also have cause for concern about the ability of the team to provide for the needs of the client owing to interpersonal difficulties between members of the multi-agency or multidisciplinary team that might have an indirect impact on the client. As far as possible, psychologists should seek to resolve any conflict with or between other professional colleagues by clear communication, relevant evidence and collaboratively working through the issues in reasoned argument within the context of respectful relationships.

If the situation remains unresolved for any reason, for example because it is judged not to be an issue for active management, the psychologist must make a judgement about whether their involvement in the team is helpful to the client or the working of the team. If not, the psychologist should consult with an appropriate colleague about whether they should disengage from that team.

A psychologist may also experience concerns about the competence or ethical practice of individual colleagues involved in joint working. These concerns may relate to the competence of the colleague to carry out a particular intervention, the appropriateness of an intervention for a particular client or problem, the nature of the relationship between a colleague and his or her client (e.g. potential abuses of power).

The psychologist should first approach the colleague in confidence, if it is appropriate, with relevant information, in a manner that is collegiate and helpful. If misgivings continue, the psychologist should consult with an appropriate colleague to share concerns and to seek advice. Where appropriate they should keep a written record of the meetings and steps taken to resolve any difficulties.

If they conclude that misconduct has occurred, psychologists should bring the matter to the attention of those charged with the responsibility to investigate such concerns, generally in the first instance an employer or in the case of an independent practitioner, the HCPC. Further information is available in ***Section 2.1: Working environment.***

8.4 Supporting a colleague when a complaint has been made

The receipt of a complaint or allegation can be distressing for all concerned, not least for the person who is the subject of the complaint or allegation. It is important that they receive advice and support from appropriate persons. Any potential conflicts of interest should be considered. It may be that a psychologist is not best placed to offer support and guidance as they may be called as a witness in the complaints process. Encourage colleagues to seek advice from an experienced colleague or supervisor where appropriate.

The psychologist should also be encouraged to seek the support of an accredited workplace trade-union representative who is skilled at supporting people in these situations and can access legal advice if necessary. Legal advice can also be obtained from the professional indemnity insurance broker, and sometimes from household insurance policies where the householder has taken out the legal advice additional option.

Complaints are an increasingly normal occurrence and must be handled in a professional manner. The complaint investigator or professional body will need the psychologist's version of events and any evidence before any conclusions are reached. Psychologists should support colleagues to respond promptly, objectively, factually and honestly to the complaint. The content of the complaint should always be held in confidence.

8.5 If the client remains unhappy

If any conflict or issue as referred to in this section cannot be resolved, it may be appropriate to advise a client or other individual that that they have a right to raise any concerns about a psychologist with the Health and Care Professions Council, further details of which can be found at www.hcpc-uk.org

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These guidelines were updated by a working group of the Professional Practice Board of the British Psychological Society. The working group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice. Thanks are due to the members of the working group, and to the founder authors of the first and second editions of the guidelines whose work is the core and the foundation stone of the current edition.

Role	**Name**
Chair of the Practice Guidelines Working Group	Nicola Gale
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Clinical Psychology	Tejinder Kondel and Ste Weatherhead
Coaching Psychology	Paul Philipps
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Ethics	Martin Fisher
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Mental Capacity Advisory Group	Gemma Gray

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Mental Health Act Advisory Group	John Taylor
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Administrator	Emma Smith
Editorial Support	Sally Anderson
Policy Advisor (Professional Practice)	Hannah Farndon

Appendix 1 – Relevant legislation

Unless otherwise stated, Acts can be found on the government website
http://www.legislation.gov.uk/

United Kingdom and England

Care Act 2014

An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

Care Standards Act 2000

An Act to establish a National Care Standards Commission; to make provision for the registration and regulation of children's homes, independent hospitals, independent clinics, care homes, residential family centres, independent medical agencies, domiciliary care agencies, fostering agencies, nurses agencies and voluntary adoption agencies; to make provision for the regulation and inspection of local authority fostering and adoption services; to make provision for the registration, regulation and training of those providing child minding or day care' to make provision for the protection of children and vulnerable adults; to amend the law about children looked after in schools and colleges.

Children Act 1989

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Children and Families Act 2014

An Act to make provision about children, families, and people with special educational needs or disabilities; to make provision about the right to request flexible working; and for connected purposes.

Data Protection Act 1998

An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. The Act states that anyone who processes personal information must comply with eight principles, which make sure that personal information is:

- fairly and lawfully processed;

- processed for limited purposes;
- adequate, relevant and not excessive;
- accurate and up to date;
- not kept for longer than is necessary;
- processed in line with your rights;
- secure; and
- not transferred to other countries without adequate protection.

Equality Act 2010

An Act to make provision to require Ministers of the Crown and others when making strategic decisions about the exercise of their functions to have regard to the desirability of reducing socio-economic inequalities; to reform and harmonise equality law and restate the greater part of the enactments relating to discrimination and harassment related to certain personal characteristics; to enable certain employers to be required to publish information about the differences in pay between male and female employees; to prohibit victimisation in certain circumstances; to require the exercise of certain functions to be with regard to the need to eliminate discrimination and other prohibited conduct; to enable duties to be imposed in relation to the exercise of public procurement functions; to increase equality of opportunity; to amend the law relating to rights and responsibilities in family relationships; and for connected purposes.

Health and Social Care Act 2012

An Act to establish and make provision about a National Health Service Commissioning Board and clinical commissioning groups and to make other provision about the National Health Service in England; to make provision about public health in the United Kingdom; to make provision about regulating health and adult social care services; to make provision about regulating health and social care workers; to make provision about public involvement in health and social care matters, scrutiny of health matters by local authorities and co-operation of health care services; to make other provision about information relating to health or social care to make other provision about health care; and for connected purposes.

Mental Capacity Act 2005

An Act to make new provision relating to persons who lack capacity; to establish a superior court of record called the Court of Protection in place of the office of the Supreme Court called by that name; to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13th January 2000; and for connected purposes.

Mental Health Act 1983 as amended 2007

An Act to consolidate the law relating to mentally disordered persons. The main purpose of the Mental Health Act 1983 as amended 2007 (MHA) is to allow compulsory action to be taken, where necessary, to ensure that people with mental disorders receive the care and treatment they require for their own health or safety, or for the protection of other people.

Offender Rehabilitation Act 2014

An Act to make provision about the release, and supervision after release, of offenders; to make provision about the extension period for extended sentence prisoners; to make provision about community orders and suspended sentence orders; and for connected purposes.

Official Secrets Act 1989

An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information.

Regulation of Investigatory Powers Act (RIPA) 2000/Investigatory Powers Act 2016

An Act to make provision for and about the interception of communications, the acquisitions and disclosure of data relating to communications, the carrying out of surveillance, the use of human intelligence sources and acquisitions of the means by which electronic data protected by encryption or passwords may be decrypted or accessed; equipment interference, bulk personal datasets and other information; to make provision about the treatment of material held as a result of such interception, equipment interference or acquisition or retention; to establish the Investigatory Powers Commissioner and other Judicial Commissioners and make provision about them and other oversight arrangements; to make further provision about investigatory powers and national security; to amend sections 3 and 5 of the Intelligence Services Act 1994.

Safeguarding Vulnerable Groups Act 2006

An Act to make provision in connection with the protection of children and vulnerable adults. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

Northern Ireland

Children Act 1989 – NI has a Criminal Justice Children's Order 1998

An Act to reform the law relating to children; to provide for local authority services for children in need and others; to amend the law with respect to children's homes, community homes, voluntary homes and voluntary organisations; to make provision with respect to fostering, child minding and day care for young children and adoption; and for connected purposes.

Criminal Justice (Northern Ireland) Act 2013

An Act to amend the law relating to sex offender notification, sexual offences prevention orders and human trafficking; to provide for the destruction, retention, use and other regulation of certain fingerprints and DNA samples and profiles; to provide for the release on license of persons detained under Article 45(2) of the Criminal Justice (Children) (Northern Ireland) Order 1998.

Criminal Justice (Northern Ireland) Order 2008 and Public Protection Arrangements in Northern Ireland (PPANI)

The Criminal Justice (NI) Order 2008 introduced a new sentencing framework, including extended and indeterminate sentences for public protection to reduce the risk of dangerous sexual and violent offenders being released into the community until the risk they pose is considered by the parole commissioners to be at a manageable level. The Public Protection Arrangements in Northern Ireland (PPANI) contained within the Criminal Justice (NI) Order 2008, place a duty on a number of agencies, within the criminal justice sector and elsewhere, to cooperate in the interest of better assessment and management of risk posed by serious sexual and violent offenders.

Justice Act (Northern Ireland) 2015

An Act to provide for a single jurisdiction for county courts and magistrates' courts; to amend the law on committal for trial; to provide for prosecutorial fines; to make provision in relation to victims and witnesses in criminal proceedings and investigations; to amend the law on criminal records and live links; to provide for violent offences prevention orders; to make other amendments relating to the administration of civil and criminal justice; and for connected purposes.

Mental Capacity Act (Northern Ireland) 2016

This Act fused mental health and mental capacity law into a single piece of legislation. The Act provides a framework for broader decision-making which includes: a statutory presumption of capacity, a requirement to support decision-making, mechanisms to allow individuals to plan for times that they do not have capacity, and safeguards to protect the rights of individuals when compulsory interventions or substitute decisions are required. It will remove the ability for someone to be treated for a mental health condition against his or her wishes if he or she retains the capacity to refuse such treatment, thus putting it on a par with the rights that individuals currently enjoy to make decisions regarding physical health treatment.

The Parole Commissioners' Rules (Northern Ireland) 2009

The Parole Commissioners for Northern Ireland are an independent body responsible for making decisions on the release and recall of prisoners sentenced to life, indeterminate custodial sentences, and extended custodial sentences, as well as the recall of prisoners serving determinate sentences.

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (Northern Ireland) Order 2008 lowered the age of sexual consent from 17 to 16 and incorporated significant changes to the law in relation to sexual offences in Northern Ireland; better protection for young people and people with a mental disorder from sexual abuse and exploitation; and sought to clarify issues surrounding consent in sexual assault cases and rape.

Scotland

Adoption and Children (Scotland) Act 2007

An Act of the Scottish Parliament to restate and amend the law relating to adoption; to make other provision in relation to the care of children; to enable provision to be made in relation to allowances in respect of certain children; and for connected purposes.

Adults with Incapacity (Scotland) Act 2000

An Act of the Scottish Parliament to make provision as to the property, financial affairs and personal welfare of adults who are incapable by reason of mental disorder or inability to communicate; and for connected purposes.

Adult Support and Protection (Scotland) Act 2007

An Act of the Scottish Parliament to make provision for the purposes of protecting adults from harm; to require the establishment of committees with functions relating to the safeguarding of adults who are at risk of harm; to amend the law relating to incapable adults; to allow the Public Guardian to intervene in court proceedings; to amend the law relating to mentally disordered persons; and for connected purposes

Children (Scotland) Act 1995

An Act to reform the law of Scotland relating to children, to the adoption of children and to young persons who as children have been looked after by a local authority; to make new provision as respects the relationship between parent and child and guardian and child in the law of Scotland; to make provision as respects residential establishments for children and certain other residential establishments; and for connected purposes.

Children and Young People (Scotland) Act 2014

An Act of the Scottish Parliament to make provision about the rights of children and young people; to make provision about investigations by the Commissioner for Children and Young People in Scotland; to make provision for and about the provision of services and support for or in relation to children and young people; to make provision for an adoption register; to make provision about children's hearings, detention in secure accommodation and consultation on certain proposals in relation to schools; and for connected purposes.

Mental Health (Scotland) Act 2015

An Act of the Scottish Parliament to amend the Mental Health (Care and Treatment) (Scotland) Act 2003 in various respects; to make provision about mental health disposals in criminal cases; to make provision as to the rights of victims of crime committed by mentally-disordered persons; and for connected purposes.

Mental Health (Care and Treatment) (Scotland) Act 2003

An Act of the Scottish Parliament to restate and amend the law relating to mentally disordered persons; and for connected purposes.

Protection from Abuse (Scotland) Act 2001

An Act of the Scottish Parliament to enable a power of arrest to be attached to interdicts granted to protect individuals from abuse; to regulate the consequences of such attachment; and for connected purposes.

Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005

An Act of the Scottish Parliament to make it an offence to meet a child following certain preliminary contact and to make other provision for the purposes of protecting children from harm of a sexual nature, including provision for implementing in part Council Framework Decision 2004/68/JHA; and to make further provision about the prevention of sexual offences.

Protection of Vulnerable Groups (Scotland) Act 2007

An Act of the Scottish Parliament to bar certain individuals from working with children or certain adults; to require the Scottish Ministers to keep lists of those individuals; to make further provision in relation to those lists; to establish a scheme under which information about individuals working or seeking to work with children or certain adults is collated and disclosed; to amend Part 5 of the Police Act 1997; to amend the meaning of school care accommodation service in the Regulation of Care (Scotland) Act 2001; and for connected purposes

Public Bodies (Joint Working) (Scotland) Act 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

Regulation of Care (Scotland) Act 2001

An Act of the Scottish Parliament to establish the Scottish Commission for the Regulation of Care and the Scottish Social Services Council; to make provision for the registration and regulation of care services and for the registration, regulation and training of social service workers; to enable local authorities to provide and maintain residential accommodation in which nursing is provided; to make further provision as respects persons who have been looked after by local authorities; to amend the definition of ‘place of safety’ in the Children (Scotland) Act 1995.

Smoking, Health and Social Care (Scotland) Act 2005

To amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland

Social Care (Self-directed Support) (Scotland) Act 2013

An Act of the Scottish Parliament to enable local authorities to provide support to certain carers; to make provision about the way in which certain social care services are provided by local authorities; and for connected purposes.

Vulnerable Witnesses (Scotland) Act 2004

An Act of the Scottish Parliament to make provision for the use of special measures for the purpose of taking the evidence of children and other vulnerable witnesses in criminal or civil proceedings; to make provision about the admissibility of expert psychological or psychiatric evidence as to subsequent behaviour of the complainer in criminal proceedings in respect of certain offences to make provision about the admissibility of certain evidence bearing on the character, conduct or condition of witnesses in proceedings before a sheriff relating to the establishment of grounds of referral to children's hearings; to abolish the competence test for witnesses in criminal and civil proceedings; and for connected purposes.

Wales

The Mental Health (Wales) Measure 2010

This measure places new legal duties on local health boards and local authorities in Wales in relation to the assessment and treatment of mental health problems. The Measure became law in December 2010 and there are 4 parts to it which are as follows:

- Part 1 ensures that there are more mental health services are available within primary care.
- Part 2 makes sure all patients in secondary services have a Care and Treatment plan.
- Part 3 enables all adults discharged from secondary services to refer themselves back to those services.
- Part 4 supports every in-patient to have help from an independent mental health advocate if wanted.

Social Services and Well-being (Wales) Act 2014

An Act of the National Assembly for Wales to reform social services law; to make provision about improving the wellbeing outcomes for people who need care and support and carers who need support; to make provision about co-operation and partnership by public authorities with a view to improving the wellbeing of people; to make provision about complaints relating to social care and palliative care; and for connected purposes.

Violence against women, Domestic Abuse and Sexual Violence (Wales) Act 2015

An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse and sexual violence; to improve arrangements for the protection of victims of such abuse and violence; to improve support for people affected by such abuse and violence; and to require the appointment of a National Adviser on gender-based violence, domestic abuse and sexual violence.

Well-being of Future Generations (Wales) Act 2015

An Act of the National Assembly for Wales to make provision requiring public bodies to do things in pursuit of the economic, social, environmental and cultural wellbeing of Wales in a way that accords with the sustainable development principle; to require public bodies to report on such action; to establish a Commissioner for Future Generations to advise and assist public bodies in doing things in accordance with this Act; to establish public services boards in local authority areas; to make provision requiring those boards to plan and take action in pursuit of economic, social, environmental and cultural wellbeing in their area; and for connected purposes.

Appendix 2 – Websites and further information

British Psychological Society – www.bps.org.uk

The Society website has guidance, advice and further information on many topics not covered in these guidelines as well as those mentioned.

Psychologists working in clinical fields will also need to take account of Clinical Guidelines produced by NICE in England and Wales https://www.nice.org.uk/ or SIGN in Scotland http://www.sign.ac.uk/

1.1 Legal and professional obligations of psychologists

HCPC – http://hcpc-uk.org
The Health and Care Professions Council website has lots of information about professional registration including the standards of proficiency for the seven protected titles and information about indemnity insurance

Information Commissioner's Office – https://ico.org.uk/
The ICO website contains lots of useful information for organisations, private practitioners and the public regarding the rights and responsibilities under the data protection and Freedom of Information Acts.

DBS Checks – https://www.gov.uk/disclosure-barring-service-check
The government website provides helpful information for employers regarding these checks.

1.2 Continuing professional development

The HCPC has provided guidance regarding CPD for registrants. http://www.hcpc-uk.org/cpd

2.1 Working environment

Lone Working

Suzy Lamplugh Trust – http://www.suzylamplugh.org/

The Suzy Lamplugh Trust campaigns for personal safety and has lots of advice for people working alone to help to keep safe. They have some good advices and resources available.

Harassment and Bullying

ACAS – http://www.acas.org.uk/
The Advisory, Conciliation and Arbitration Service (ACAS) is a statutory organisation providing help and advice for employers and employees. They have produced guidance on several topics including harassment and bullying aimed separately at employers and employees.

Whistleblowing

Whistleblowing for employees – https://www.gov.uk/whistleblowing

The government has produced some guidance for employees surrounding whistleblowing including what to do and what to expect.

2.2 Working in the digital age

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – http://www.hhs.gov/hipaa/

This American act makes provisions for health information privacy. The government website provides information for professionals regarding this act.

N.B This Act is ONLY law for practice in America.

Social Media

The HCPC has provided guidance regarding the use of social media by professional psychologists.

http://www.hcpc-uk.org/Assets/documents/100035B7Social_media_guidance.pdf

3. Safeguarding

Statutory guidance Working together to safeguard children – https://www.gov.uk/government/publications/working-together-to-safeguard-children–2
Statutory guidance on inter-agency working to safeguard and promote the welfare of children.

Getting it Right for Every Child (GIRFEC) and the Early Years Framework – http://www.maternal-and-early-years.org.uk/getting-it-right-for-every-child-principles-and-values
This is an NHS Scotland approach which establishes the principle of giving all children and young people the best possible start in life as a priority for all services.

UK Government Guidance – https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care
No Secrets sets out a code of practice for the protection of vulnerable adults.

It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. They should collaborate with the public, voluntary and private sectors and they should also consult clients, their carers and representative groups. Local authority social services departments should co-ordinate the development of policies and procedures.

Protection of vulnerable adults scheme (POVA) – http://www.scie.org.uk/publications/guides/guide03/law/adults.asp
Individuals should be referred to, and included on, the POVA list if they have abused, neglected or otherwise harmed vulnerable adults in their care or placed vulnerable adults

in their care at risk of harm. By making statutory checks against the list, providers of care must ensure they do not offer such individuals employment in care positions. POVA checks are requested as part of disclosures from the Criminal Records Bureau.

Prevention and Protection in Partnership 2015 – https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

This policy from Northern Ireland is for all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. It sets clear and proportionate safeguarding expectations across the range of organisations.

Modern Slavery and the national referral mechanism (NRM) – https://www.gov.uk/government/collections/modern-slavery
These pages provide details about the government's work to end modern slavery, including details about how to refer victims into the NRM.

Let's talk about it – http://www.ltai.info/about/
Let's Talk About It is an initiative designed to provide practical help and guidance to the public in order to stop people becoming terrorists or supporting terrorism.

4. Managing data and confidentiality

Information Commissioners Office – https://ico.org.uk/
The Information Commissioners Office produces guidance with regards to data sharing and the Data protection and Freedom of information Acts.

HCPC guidance on confidentiality – http://www.hcpc-uk.co.uk/assets/documents/100023F1GuidanceonconfidentialityFINAL.pdf
The HCPC has provided guidance on confidentiality for registrants.

NHS – https://digital.nhs.uk/article/402/Information-Governance
The NHS has produced guidance regarding Information Governance and security for NHS and partner organisations. The NHS has codes of practice for Records management and Confidentiality.

Caldicott Report – https://www.gov.uk/government/publications/the-information-governance-review
A review was commissioned in 1997 by the Chief Medical Officer of England owing to increasing concern about the ways in which patient information is being used in the NHS in England and Wales and the need to ensure that confidentiality is not undermined. Such concern was largely due to the development of information technology in the service, and its capacity to disseminate information about patients rapidly and extensively. A committee was established under the chairmanship of Dame Fiona Caldicott. The Caldicott Report highlighted six key principles, and made 16 specific recommendations. In 2012 Dame Caldicott produced a follow up report which made 26 further recommendations including the addition of a seventh principle.

Psychological Testing Centre – http://ptc.bps.org.uk/ptc/guidelines-and-information

The PTC website contains lots of guidance about psychometric testing and the management of data generated from those tests.

5. Transparency and duty of candour

Care Quality Commission –
http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
The CQC has produced Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare with regards to duty of candour.

Appendix 3 – How this document has been developed

In developing these guidelines, the overall aim and scope of the guidelines was considered at length, and the decision arrived at that they should be applicable to all psychologists irrespective of registration status or practice context. The guidelines have therefore been written in a way which it is hoped is inclusive of the various contexts of practice. Drawing on a broad stakeholder group for the development work, the guidelines aim to cover all the important considerations for practice. It is however recognised they cannot cover every circumstance and also that new issues arise which will require careful consideration by the individual psychologist.

The Practice Guidelines development Working Group was constituted to include all of the member networks of the Society whose members engage in practice, including the HCPC registered practitioners. It included representatives of the Society's national branches in Scotland, Wales and Northern Ireland, in order to ensure applicability to the different national contexts. It also included representation from the expert working groups of the Society's Professional Practice Board and others on specialist topics of practice.

The content of the guidelines has been developed from a combination of revision of the previous edition in the light of professional consensus on current expectations of a good standard of practice of psychology; inclusion of key points from other Society guidance on specific topics with reference to further guidance; and in some cases development of new material drawing on the professional experience of our members or outside professionals in the field. The working group has not used systematic methods to search for or assess the evidence for the material included. Recommendations have been included based on working group consensus. Where there are known areas of professional difference of opinion this has been stated.

A draft of the guidelines was circulated for Society wide consultation and one month allowed for comment. This included circulation to Experts by Experience (psychology service user representatives) with whom the Society works in various contexts. The Guidelines were also sent for comment to the Health and Care Professions Council as the statutory regulator for practitioner psychologists. Comments received were considered carefully by the Working Group and changes made to the text of the guidelines where considered necessary. The annotated audit sheet of the comments received and disposal was provided to a meeting of the Society's Professional Practice Board to assist its consideration of the draft guidelines, by way of final peer scrutiny. The guidelines were reviewed by the Society's legal advisers prior to publication. Final approval of the guidelines was given by the Society's Board of Trustees.

The guidelines will be reviewed and updated in accordance with Society policy after five years or sooner if circumstances indicate this is needed.

To ensure clarity and presentation in a user friendly format, the Guidelines have been edited by professional staff within the Society and the format designed by the Society's Preparation for Print specialists. Where considered helpful, links have been made to additional web based resources, both to assist practitioner development and to provide up to date information in areas where there is frequent change. Organisational providers of psychological services are encouraged to review how these guidelines are used in practice and feed back to the Society any barriers to application.

In ensuring an appropriate level of independence in the production of these Guidelines, the Society has ensured its conflict of interest policy has been complied with and that no member of the working group's input has been compromised by a conflict of interest. No member has received any form of remuneration other than reimbursement of travel and subsistence expenses in accordance with Society policy. The large size of the working group and peer scrutiny and challenge, as well as the robust consultation process, guards against the potential for any one member or small group of members inappropriately to bias the Guidelines.

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SECTION 8 APPENDIX 7

The
British
Psychological
Society

Division of Clinical Psychology

Record Keeping: Guidance on Good Practice

Dr Sarah Newton

Contents

Introduction

All Clinical Psychologists must exercise their professional responsibility with regard to record keeping. This is the case whether they are keeping separate psychology records or working in integrated records; whether they are in paper or electronic formats (or using both in parallel); whether in public, private or voluntary sectors; whether working in a clinical capacity, completing evaluative, audit or research activities; or undertaking pre qualification training or post-qualification CPD activities. This guidance can be used a stand-alone document and is also to be made available as a section in the *Professional Practice Guidelines*.

This guidance replaces the DCP publication, *Clinical Psychology and Case Notes: Guidance on Good Practice*, published by the Society in 2000. The pace of change with regard to records means that any document published now may be out of date within months. The guidance should, therefore, be read in conjunction with the prevailing legal, Department of Health and employing organization's standards and requirements. Such information is readily available on the relevant websites (e.g. www.doh.gov.uk, *Standards for Better Health*, 21 July, 2004, updated 3 April, 2006). Whatever the working context adherence to core standards will ensure psychologist's records are:

- of the highest standard required and auditable;
- accessible and useable by clinicians and managers who have a 'need to know' or clients who have requested copies;
- meet specified requirements for format, method of recording, content, storage, access and archiving;
- serve their primary purpose in recording the care of individuals through the work of the clinician.

Psychologists working in the NHS will be working within the framework of *Standards for Better Health*. Information management and record keeping have specific mention in:

- First domain – Safety C1 a and b;
- Second domain – Clinical and cost effectiveness C5;
- Third domain – Governance C9, C10b, D6;
- Fourth domain – Patient focus C13 b and c, C16;

Matters of confidentiality and privacy are also referred to in other domains (e.g. Sixth domain – Care environment and amenities C20).

Additionally, those in the NHS will have a Knowledge and Skills Framework outline that relates to their professional development. Whilst all core and additional dimensions refer to records to some degree the following are examples of those having particular relevance:

- Core Dimension 1: Communication;
- Dimension HWB2: Assessment and Care Planning to meet Health and Well-being needs;
- Dimension HWB6: Assessment and Treatment Planning.

Thus, within the KSF, record keeping is considered an important skill where levels of competence can be developed over time. These and other KSF skills and competencies are the focus of the Department of Health's Skills for Health developments.

Legal and ethical considerations are set out in the Society's and DCP publications relating to *Professional Practice* (1995), *Code of Ethics and Conduct* (2006). The Department of Health and the National Health Service Litigation Authority provide detailed information relating to individual and corporate legal responsibilities (e.g. *Records Management: NHS Code of Practice Parts 1 and 2*, 5 April, 2006; *NHS Information Governance – Guidance on Legal and Professional Obligations*, 2007).

Although the sources for this guidance are predominantly for the UK or England, reference is made throughout the text to some of the key documents and directives as they apply to those psychologists working in Northern Ireland, Scotland and Wales. The Department of Health and the Office of Public Sector Information provide links to relevant sources for the UK as a whole and to each of the devolved nations.

The late Karen Ehlert started this work with Dr Tony Wainwright and contributions from Dr Sarah Newton. It was further developed at the DCP Strategy meeting in April, 2006, with a number of interested parties and David Trickey who was revising the *Professional Practice Guidelines.* The existing guidelines written in 2000 by Dr Peter Harvey were excellent but are now out of date. Those parts that have continuing relevance have been retained.
In addition Dr Bernard Kat published 'Use of electronic records as the professional record' in *The Psychologist* (January, 1998, pp.23–26). He explored the issues that are now present as the NHS moves towards electronic records with single 'files' for each person. Professor Michael Berger has subsequently researched and written two useful papers 'Implementing the NHS vision for clinical information systems: some issues and implications for clinical psychology services' (Berger, 2007a) and a paper on 'A functional approach to clinical practice: introducing the international classification of functions and its implications for clinical psychology' (Berger, 2007b). Both refer to activity recording and coding and the former specifically looks at some major issues relating to all forms of electronic record keeping as might be applicable in the professional practice of clinical psychology. Professor Michael Berger and

Dr Adrian Skinner have written an informative and helpful update on the progress and challenges in the development of electronic record systems for the profession (2008). Their support and advice in the preparation of this record keeping guidance has been invaluable.

The present guidance is intended to be useable by psychologists regardless of working contexts. Psychologists should adhere to the highest standards whether in these professional guidelines or their employer's policies. Clinical Psychologists will, in any given situation, take guidance into account along with their employer's policies, prevailing mandatory national and local standards and their own clinical judgment.

The question and answer format should address the key areas for practice and of concern. The guidance will be reviewed at least bi-annually by the DCP's Professional Standards Unit and may be amended and extended to incorporate the latest directives and additional questions and answers not yet apparent.

Guidance on Good Practice: Frequently asked questions and answers

Who owns the records?
Kat (1998) noted a number of points in relation to ownership and touched on what might be similarities and differences with paper and electronic records as well as ethical matters regarding access. The prevailing view is that records belong to the employing organization that also has the responsibility for exercising archiving and destruction at the appropriate time. They are contributed to by the professional working with the person.

The Data Protection Act 1998 (effective from 1 March, 2000) governs access to the health records of living people. The Access to Health Records Act 1990 governs access to the health records of deceased people (Appendix 2 DOH Record Keeping – Frequently asked questions).

Can records be confidential?
While it is essential to assure clients that you will be working in a context where confidentiality is extremely important and only those with a need to know should be able to access information, confidentiality cannot be absolute (e.g. where there may be issues of over-riding public or personal safety, child protection, vulnerable adults). Information can be requested by the courts and by the person the records relate to. At times the requests of service users and their representatives may be at variance with professional codes or organizations policies. Reference to appropriate documents and legal advice for the professional and employing organizations will be essential in order to resolve these matters.

Computer-held records mean that the information held is accessible by an increased number of people not just in the NHS in England but potentially outside the NHS and across the world. There is scope for preventing access to certain information in such records through a process of sealing. Patient Sealing and Clinician Sealing of information in the electronic records is planned for 2008/9 (*'Sealed Envelopes' Briefing Paper: 'Selective Alerting' Approach,* 2006, Crown Copyright). Contemporaneous and retrospective sealing will be possible, but not prospective sealing. Parts of records may be sealed and the duration of the sealing specified. This activity is dependent on the development and implementation of the NHS computer systems in the Connecting for Health programme.

The Society's *Code of Ethics and Conduct* (2006) states that psychologists should:

i. Keep appropriate records.
ii. Normally obtain the consent of clients who are considered legally competent or their duly authorized representatives, for disclosure of confidential information.
iii. Restrict the scope of disclosure to that which is consistent with professional purposes, the specifics of the initiating request or event, and (so far as required by the law) the specifics of the client's authorization.
iv. Record, process and store confidential information in a fashion designed to avoid inadvertent disclosure.

And with regard to confidentiality should:

v. Ensure from the first contact that clients are aware of the limitations of maintaining confidentiality, with specific reference to: (a) potentially conflicting or supervening legal and ethical obligations; (b) the likelihood that consultation with colleagues may occur in order to enhance the effectiveness of service provision; and (c) the possibility that third parties, such as translators or family members, may assist in ensuring that the activity concerned is not compromised by a lack of communication.

Further information can be accessed in Confidentiality: NHS Code of Practice at www.dh.gov.uk and via publications for each of the devolved nations on their NHS sites (e.g. Wales Centre for Health, Data Protection and Confidentiality Policy, December, 2005). The Common Law Duty of Confidentiality (cited on pp.51–53 Records Management: NHS Code of Practice, 5 April, 2006) describes three circumstances for the lawful disclosure of confidential information. These include where the client has given consent (where disclosure is to be outside the team caring for them), where disclosure is in the public interest and where there is a legal duty to do so (e.g. a court order). Legal action can be taken by the client against the professional and the organization if confidentiality is breached if a disclosure is made that is not permitted under common law. The Care Record Guarantee: Our guarantee for NHS care records in England, August, 2007, third edition, NHS; the Information Security Management: NHS Code of Practice, April 2007, DOH, are additional sources of information with clear guidance for patients and professionals. In March, 2007, Martin Crawshaw, Chair of the Professional Practice Board, wrote on behalf of the British Psychological Society to the Commons Health Select Committee Inquiry into the Electronic Patient Record and its Use. The response detailing the Society's views about EPR was prepared by members of the DCP Informatics sub-committee, Dr Adrian Skinner (Chair) and Professor Michael Berger.

What is a record?

For those working in NHS contexts a record is:

> Anything which contains information (in any media) which has been created or gathered as a result of any aspect of the work of NHS employees (HSC 1999/53, Appendix A, para 5.1).

This is easily applicable in other non-NHS contexts too. The key points are that all and any material can be part of the record and that includes handwritten, computer typed and filed, audio and visual recordings, proformas used in assessments, records made by the client, creative work completed by the client (e.g. artwork). Electronic information including e-mails and mobile phone texts will need to be addressed. This applies both to communications within and between teams and/or services caring for a client or client group and to the communications between professionals and their clients. Their status as of 2007 is contentious both in terms of confidentiality and how one makes and places a record in the electronic or paper file. Advancements in technology and increasing acceptance of ways of communicating with clients that reflect societal developments will influence progress in this area and adjustments to national standards.

Records management: NHS Code of Practice Parts 1 and 2, 5 April, 2006, makes reference to electronic communications but not in sufficient detail for absolute answers to the questions of professionals in the situations described above. The Data Protection Act 1998 defines a record as consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual. Refer also to the Data Protection and the Freedom of Information (Scotland) Acts 1998 and 2002. The Department of Health, Social Services and Public Safety in Northern Ireland has(as have the other devolved nations) produced guidelines for managing records in health and personal social services (December, 2004, updated December, 2006).

Can Clinical Psychologists keep separate notes?

It is the intention of the DOH that there will be a single record for each person who uses the services. This has already happened in some NHS services across the country. For some this is a single paper record, for others a single computerized record (whether set up specifically or scanned paper records) and in some areas both exist in parallel while the technology is made available for the transition to computer records only. Ultimately the NHS is working towards single electronic records. There are continuing discussions about safeguarding the information and accessibility that include reference to data protection and within that confidentiality.

Refer to several sites for the latest information (e.g. www.informatics.nhs.uk). The Health Informatics Community (HIC) can be found on the eSpace environment http://www.espace.connectingforhealth.nhs.uk/. There are also e-Bulletins available from NHS Connecting for Health by e-mail at nhscfh.ebulletins@nhs.net.

What is the justification, if any? In the past psychologists have stated that process notes should not be shared. Process notes are part of the record and, therefore, subject to the same status as any other part of the record.

What are process notes? If these are notes made during a session they will need to be written up in the record to ensure they are properly set out (date, time, codes for activity, signature, profession, etc.), legible, no abbreviations, continuous writing (no spaces/gaps). These are then a record of that meeting and the views of the professional. The original rough notes may then be shredded. The formal recording can be supported with letters to others of relevance to the client with letters that detail assessment, formulations, plans for the intervention and work together and outcomes.

What would I wish for were I or someone close to me receiving care? You would want the team/service professional to be up-to-date and able to take key information into account in providing a service. If separate notes are to be kept and if working in the NHS, this is supported, then timely updating through typed correspondence and meetings/reviews will be an important way to share such information and also gain it for ones own work with the client. If a separate record is being kept then there are additional matters to organize. These include ensuring there is notification of the existence of the psychology record in the main/official/multidisciplinary/medical file. Entries should also be made in these files and/or letters written and copied to them to keep others involved in a person's care up to date.

What happens when I have discharged someone and have a separate file for them?
In the NHS Psychology records are subject to the same standards for archiving and retrieval as other records. There are times records are to be kept for and these vary according to the age when the client was first seen, the reason they were being seen (i.e. for mental or physical health care) and if they have died. The practical issue in NHS Trusts is how to link together all the records that relate to the one person and whether the official storage facility will take psychology records that are sometimes viewed in a different capacity to the official medical record. One way some have approached this is to attach the psychology record in a sealed section in the 'official' record at the point of discharge. As noted earlier, electronic 'Sealing' and restricting access is under development in relation to computer held records. Professionals who do this will have to justify why and when the sealing can be taken off the records and

confirm who is empowered to unseal. The administration in doing this will need to be thought through, as for example, when psychologists move jobs and leave sealed parts of records which may require unsealing or where the reason for sealing in the first place has expired.

The Connecting for Health website gives the latest information about electronic records and sealing. Also refer to the DOH Records Management: NHS Code of Practice, 5 April, 2006. The Scottish Executive Health Department has issued guidance on retention periods (2005).

Should Clinical Psychologists contribute to the shared record?

Yes within teams, services and organisations. There is a professional responsibility to inform others involved in a person's care of your involvement, when contact has occurred, what work is being done and what work is intended and when. All entries in the shared records must comply with the national and local standards. For example, the Care Programme Approach in mental health has a specified set of paperwork to complete. Compliance with the standards for the content of entries is obligatory whether paper or electronic records are being kept. However, information sharing across organizations, some of which may be outside the NHS, should be compliant with current guidance and reference made to advice within your organization before doing so, for example, if appropriate, through the legal department and Caldicott Guardian (Department of Health, 7 January, 2005, NHS Caldicott Guardians; Scottish Executive Health Department (MEL, 1999) Protecting and using patient information: a manual for Caldicott Guardians). There are implications of the single record approach for psychologists working within the non NHS organizations, both for contributing to a shared record (e.g. in social services or a voluntary organization) and sharing information with other organizations. Again, advice should be sought from the employing organization and professional body in order to clarify the appropriate way forward.

Our Health, Our Care, Our Say White Paper Brief Guide (2006) states that 'services will share information about the people in their care so that health, housing, benefits and other needs are considered together. By 2008, anyone with long term health and social care needs should have an integrated Personal Health and Social Care Plan, if they want one' (p.20). The Scottish Executive have produced Better Health, Better Care (August, 2007) following a two-year period of consultation and discussion.

What might be the exceptions to contributing to the shared record?

It is difficult to think of a situation where one might think no contact with others involved in a person's care is justified. Even when in private practice correspondence should be exchanged with a referrer and others involved in that person's care.

Who can access the record?

Clients can access their records and if they have agreed should be receiving copies of correspondence about themselves anyway (Department of Health, 30 April, 2003, copying letters to patients: good practice guidelines). Each organization, NHS or otherwise, will have a procedure for people to access their own records. They cannot access records relating to other people except in specific contexts relating to capacity where it has been possible, prior permissions having been given or arranged (as would be the case with Enduring, and from 1 October, 2007, Lasting Power of Attorney).

Professionals not directly connected with the care and administration (secretarial and audit) of that care are not entitled to access the information unless it is to complete specific tasks relating to their working context. Only those with a 'need to know' can justify access. In certain circumstances information can be released with client's permission and can be asked for by courts if there is a matter of public interest

The Common Law Duty of Confidentiality describes access considerations (Records Management: NHS Code of Practice, 5 April, 2006, pp.51–53). How to see your Health Records is one example of an information leaflet available to the public in Scotland. The Welsh Assembly Government has recently issued a code of practice on access to information (2007).

Are there special issues with children?

Yes. All psychologists should be familiar with the latest directives with regard to children. Confidentiality and access to records have been mentioned in previous sections.

Information may be obtained from The Children Act 2004 and the most recent development with the full implementation of the Common Assessment Framework CAF in 2007. The Mental Health Bill 2006 (introduced to the House of Commons on 7 March, 2007) amends the Mental Capacity Act 2005 to incorporate safeguards from Bournewood.

Are there special issues with vulnerable adults?

Yes. All psychologists should be familiar with the latest directives with regard to vulnerable adults.

Department of Health. (17 May, 2006). Protection of vulnerable adults scheme in England and Wales for adult placement schemes, domiciliary care agencies and care homes: A practical guide.

The Mental Health Bill 2006 (introduced to the House of Commons on 7 March. 2007) amends the Mental Capacity Act 2005 to incorporate safeguards from Bournewood.

See also Protection of vulnerable groups (Scotland) Act 2007 and Adults with Incapacity Act 2000.

How should psychologists' notes be managed?

Paper records must be kept physically secure. Psychologists must adhere to their employer's organizational policies with regard to storage.

Can letters form part of the record?

Letters are part of the record. They must be dated and signed and contain information relating to dates seen, problems with appointments, assessment, formulation, plan for intervention and work and outcomes. Copies should be made available for clients unless they have opted out of receipt of these or have a nominated person to receive them. Letters received in relation to the care of clients are part of the record for that person. There are specific procedures following requests for information that may result in some letters or reports being removed from the copied record before it is sent of to the person or organization who requested it. For example, reference to third parties and Child Protection Meeting minutes may well be excluded from the copied record under certain circumstances.

What should happen to materials from psychological assessments?

Published forms used to record performance and paperwork completed by clients during the course of assessments (some will be hand-written/drawn on blank A4 sheets) are part of the record for that client. There are significant concerns about these materials and the reports that are written by psychologists based on the results. These centre around infringement of copyright is forms are photocopied before or after use; access by people who may not 'need to know'; invalidation of the assessment for repetition with the client at a future date or for use with clients in the future (as the assessment will be in the public domain) and misinterpretation of results by professional and lay people.

The British Psychological Society has published a code of good practice for psychological testing (2005). In October, 2007, the Society's Psychological Testing Centre produced a 'Statement on the conduct of psychologists providing expert psychometric evidence to courts and Lawyers'. Professor Mike Berger and Dr Adrian Skinner (in press) recommend the use of sealed envelopes as one way of addressing some of the issues. The results needed for the care of the client would be incorporated into the shared part of the single record.

What if a client requests that their notes be destroyed at the end of treatment?

There are varying time periods for the retention of records. These are set out by the DOH. Materials they have produced during their work with you may be subject to retention (you will need to check the directive for the particular client group or service you are working in). It could also be the case that for certain forms of work such as pieces of art work, photographs they have brought in, letters or records they have written may be returned to them and notification that this has been done made in the record. They can then choose what to do with the materials. Audio and video recordings of sessions and supervision sessions should be wiped clean as soon as they have served their purpose and at the latest at the point of discharge unless the client has given signed consent for materials to be used for research or training purposes and a copy of this consent is lodged in the file. Secure storage and access to such materials must be addressed. In addition, provision must be made for contingencies as when a psychologist moves to another post leaving a cabinet full of confidential materials arising from clinical work that have no relevance to the incoming post holder.

What about activity recording?

There are different systems for recording activity across the country. These range from paper data collection to computer systems that have more or less ability to give information back to managers or clinicians in a timely and useable way. Psychologists must comply with the recording system of their employing organisation. Until the same system is available in all health care settings, new systems will need to be learned with each reorganization or move to another post.

There are also specific ways of recording that will enable audits of service activity as well as individual activity to be completed (e.g. Care Programme Approach CPA paperwork and electronic CPA, activity specified by the Mental Health Minimum Data Set MHMDS). It is not yet clear what the impact of payment by results (2007 consultation) will be on activity and record keeping by psychologists. It is likely that additional activity records will need to be kept that relate to clients' presentation and intervention and outcomes according to national standards.

When do I need to gain consent?

Whenever you are working with someone they should be given information that enables them to make an informed decision about consent to have information about them and their work with you, shared with others. This applies to work outside the team or service caring for them of which you are a part, to trainees working on case studies as part of their training, to audio and visual recording, to teaching examples, to audit, evaluation and research and publications.

Department of Health. (22 November 2001). HSC 2001/023: Good practice in consent: achieving the NHS Plan commitment to patient-centred consent practice.

BPS (March 2006). Code of Ethics and Conduct, pp.12–14, states what psychologists should do in relation to informed consent and self-determination.

Do supervision notes form part of the record?

Supervisees and supervisors should record information discussed in supervision. There may be occasions when it is clear that an entry about the discussion and decisions in supervision should also be entered into the record. From a legal standpoint anything that identifies an individual forms part of their record and can be called upon just as the full record itself in cases where the client or the court requests it or it is a matter of public interest. In practice, notes are often kept in an anonymised form. They should always be signed and dated and kept in a secure place. They will need to be kept for a significant time in case the supervisee or supervisor needs to refer to them again or is required to (e.g. disciplinary action or court requests). The exact time for retention needs clarification but may be the same as the retention of records. This clearly poses an administrative challenge as when for example, psychologists and their administrative staff move jobs or retire.

The DCP Policy on continued supervision (2006) states:
The minimum standard for the recording of supervision sessions is as follows:

- a. *Copies of all supervisory contracts and updates should be kept.*
- b. *The date and duration of each session should be recorded.*
- c. *A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.*
- d. *A written record should be made of all regular reviews, including outcomes, of supervision.*
- e. *In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement in the relevant case file.*

Back to basics

1. Use paper provided by the organization (e.g. Clinical Notes sheets and CPA paperwork).
2. Always write in black ink.
3. Do not leave spaces between lines or entries.
4. Sign and date alterations and keep the original intact (do not erase).
5. Record the date and time of the session, who was present, where it took place and as a minimum key points discussed and outcomes and action plans.
6. Write your name, sign, date and time the entries.
7. Always write up notes on the same day or the day after.
8. Avoid taking client files (or copies) 'off service premises' or home in order to write up in own time.
9. Send letters out within a week.
10. Keep anonymised notes of clinical supervision sessions to the same standards as client records and store securely.
11. Destroy recordings (audio, visual, digital) when they have been listened to/ watched or otherwise achieved their purpose.
12. Give back work that belongs to the client (materials they have produced for your work together whether writing, artistic creations, etc.) before discharge
13. Carry out all the duties and requirements for CPA paperwork if acting as Care Co-ordinator.
14. Remember that records written in the context of NHS employment are NHS property and do not belong to the person who wrote them.

Conclusions

This guidance will be updated within two years from publication. Please forward any comments and questions to the DCP office. These and the responses to them may be added to the frequently asked questions and answers section in the following edition.

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- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through the Psychologist Appointments section of *The Psychologist*, and www.psychapp.co.uk;
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- recruitment – the target is 50,000 members;
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- influence on public policy – through the work of its Policy Support Unit, Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership;
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The British
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Promoting excellence in psychology

Electronic records guidance

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Contents

Preface

This document provides guidance for psychologists working in any context where they may use, retain, manage or process electronic records. It is the formal advice of the Society to its members and is intended to provide assistance on the professional, ethical, and legal responsibilities of members contributing to these records.

The Society expects that these guidelines will be used to form a basis for consideration, with the principles being taken into account in the process of decision-making, together with the needs of others, the specific circumstances and local organisational policy. This guidance should be read in conjunction with the Society's *Code of Ethics and Conduct* and *Practice Guidelines* or *Code of Human Research Ethics*, as appropriate. Practitioner psychologists may also refer to the HCPC standards of proficiency and separate guidance regarding confidentiality[1].

This document replaces the Society's 2011 guidance. It is updated to reflect changes in practice, context and technology.

For definitions of the terms used throughout this document please see the Glossary on p.18.

Acknowledgements

This document was prepared by a working party of the British Psychological Society's Professional Practice Board.

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1. Introduction

Electronic Health Records (EHRs) are widely used by psychologists and other professionals to record, store and process health-related and personal information. Data in the individual EHRs serve multiple purposes:

- recording and communicating service user demographic and clinical characteristics;
- recording assessments, treatments, interventions and outcomes;
- local service management;
- to support commissioning and contracting requirements;
- local and national policy information requirements;
- clinical and other research.

It is important to recognise that EHRs are not just repositories of information but play a dynamic role in clinical practice. Their content can have a profound effect on what clinicians think and do, with major implications for the quality and safety of care. Increasingly the content of the record is available to be accessed, added to and commented upon by multiple staff in different services with appropriate access rights and by service users themselves. Also, with informed consent, and as appropriate and needed, information from the EHR can be shared with others involved in care, including non-NHS agencies, such as social care providers.

With the advancing sophistication and use of personal mobile technology, major software companies are creating electronic applications (apps) that enable the recording and storing of personal health-related information collected from body worn sensors and device apps that have the potential to be included in GP or other health system records. The Microsoft Health Vault[2] is an instance of such, aimed at collecting family member health information for use by healthcare services.

EHRs have proven beneficial to the quality of service delivery: an up-to-date record of interventions and findings that can be readily and immediately available to staff within and across different settings. This delivers safety, time efficiencies and increases the potential for live feedback of results to service users. EHRs can also have downsides, such as disruption of existing practice, greater demands on practitioners to gather and process information, difficulties in locating information, inappropriate information entry and record access within an organisation or through hacking or through the misuse of information and the potential for the wider propagation of poor quality information.

The use of EHRs can pose professional and ethical concerns for users and clinicians. Agencies such as NHS-Digital, The Professional Records Standards Body for Health and Social Care as well as the Department of Health in England and equivalent national health bodies and professional organisations all devote a substantial amount of effort to addressing and resolving these issues. The National Advisory Group on Health Information Technology in England's *Making IT Work* report, also known as the Wachter Report,[3] outlines a digital roadmap for the development of EHRs and system implementation in England, with relevance to the other nations.

Wachter, in his influential book *The Digital Doctor*[4] also outlines the key challenges and potential gains arising from the introduction of EHRs. Keeping a record up to date may isolate the patient from staff if done during a consultation because professionals are looking at a screen, decision making may become more precise but less personal, algorithms may deliver the wrong dose of a treatment or the wrong treatment altogether, and while data may be shared efficiently they can be invalid. Wachter's overall conclusion is optimistic but requires a medium to long term view to be taken, rather than making judgements based on current experiences, with changes involving all users, patients, clinicians, policy makers and commissioners.

As this document went to press the results of the Topol Review on preparing the healthcare workforce to deliver the digital future was published

2. The Record

The 'record', electronic or paper, is data collected in a wide array of formats to store and communicate clinical information. While certain core elements are common (name, reference number etc.), there are formats unique to the context of use and variations introduced by individual systems and the companies who sell them. This section will outline some of the types of data which feature in a record that Psychologists may encounter during their work.

The development of digital technologies is increasingly leading to records containing new and varied data formats and links to service user-specific information. This can include:

- pharmacy, radiology, information from instruments and associated clinical interpretations and reports. These data formats can be added or electronically linked to individual records.
- links to scanned and indexed paper documents including correspondence, images, drawings, psychological test pro-formas, test data and reports.
- scope for including audio and video recordings from body or other cameras and devices.
- information from smartphone or other apps, providing real-time physiological, psychological and other data. These are all components of tele-medicine, developing tele-psychology and AI applications.

These diverse forms of information pose particular challenges, for example capturing, storing, accessing, interpreting and integrating new content where the identity of the service user and the response sources may be difficult to verify. Psychologists are already facing challenges related to internet-delivered therapies, online psychological tests, email, telephone and video conversations, exercise/activity meters etc. Also, the data quality may be questionable, reflecting issues in device calibration or underlying software characteristics and errors.

2.1 A standardised clinical language for EHRs

To deal with the potential for variation in meaning and to facilitate accurate coding of clinical language and information in EHRs, special coding systems have been introduced.

SNOMED CT (Systematised Nomenclature of Medicine – Clinical Terms) is a systematically organised computer processable collection of medical terms providing numerical codes, terms, synonyms and definitions for use in clinical documentation and reporting to ensure standardisation.

Psychologists should recognise that this methodology is increasingly used within EHRs to process free text (i.e. unstructured text) and other clinical information for data analysis of, for example, prevalence, clinical activity and clinical outcomes. The Society recommends that Psychologists become involved in the implementation of such approaches to coding both in their local services and at national level to ensure the chosen system is valid and relevant to psychological practice.

2.2 Apps

Apps and online intervention programs (e-therapy) offer widespread benefit. They enable service users to use their own devices to monitor and report their mood, set reminders for actions to take or complete mood regulation techniques.

Apps and e-therapy approaches vary in their efficacy. Clinicians must evaluate them before recommending them to clients or adopting them into clinical practice. This should include consideration of the developer of the app and how any data from the app will be collected and stored and shared. Psychologists should also consider that not everyone has access to the internet at home and it may also not be appropriate to use these apps in public places.

Some apps and programs will not retain personal identifiable information and so any data captured are likely to be anonymous. Other apps may require a minimal level of identification to allow for repeat use and to display progress, however such identification may, itself, be pseudonymised. From a record keeping perspective, apps may retain person level data that are:

a) anonymous,

b) anonymous on the device but reported to the clinician by the client,

c) anonymous on the device but recoverable through an electronic key for use by the clinician,

d) have sufficient personal identifiable information to allow for the data to be exported to another system and matched with the correct record.

Where personally identifiable data may be recovered, this is subject to the Data Protection Act, 2018 for health and social care information in the same way as any other personally identifiable data processed (i.e. used) by a clinician. For further information, see Section 3 Legal Frameworks.

2.3 Portals

Portals are a way of electronically viewing personally identifiable information stored on a remote record system or database. Portals can be used in different ways depending on their access rights.

- Asynchronous portals allow for one party to write to a database and change it – for example making an appointment with a GP through an appointment booking system.
- Synchronous portals allow for two-way communication such that data may be entered, and the system then responds. Some online electronic CBT programmes have this facility.

- A ‘view only’ portal allows for personally identifiable data in one electronic system to be viewed in another. For example, Health Information Exchange in London allows for blood test results held in one hospital to be viewed by a community clinic, and for care plans in the community to be viewed by a clinician in a hospital.
- ‘Write portals’ allow clients to enter or amend data in their own record, for example to note a change of address or phone number. Opening data sources in this way, subject to appropriate governance, is broadly welcomed by service users, particularly those with complex conditions, who will, among other things, then have less need to recount their story repeatedly. This facility can also have drawbacks that need to be planned for and systematically managed, for instance when a user challenges the correctness of record content. Such integrated records are most helpfully considered to be a single record subject to Information Governance, Data Protection and Clinical Safety considerations.

2.4 Social media

Social media, whilst widespread, has until recently contained little personal identifiable information that would constitute a health record. Recent advances however indicate that the way social media is used by an individual may predict, amongst other events, suicide attempts[5]. To that end and with the service user’s permission, there is the potential for social media to be monitored for risky mood states and clinicians alerted as required.

2.5 Psychometric testing apps

Apps for psychometric test users have long been available. They can automatically convert raw test data to standardised scores and generate an initial interpretation in the form of a report. This can be very helpful as it reduces the risk of human error when making repeat calculations and cross-referencing normative tables (although not immune to any errors introduced by those who programmed the systems). These apps can sometimes produce much more detailed analyses than are practicable for clinicians to do manually. Of course, it is critical that the data entered into the apps are accurate.

As with all test results, overall clinical interpretation is essential, taking into account the psychometric robustness of particular tests, the service users’ clinical history and performance factors during testing. For these reasons, it is advised that automatically generated reports are used as a helpful starting point, rather than a finished and complete interpretation.

All the technologies mentioned in this section are evolving very quickly. Psychologists should aim to keep abreast of developments and be aware of the potential consequences. Sophisticated apps that can access personal data shared on social media could potentially be used in ways not approved by the individual concerned.

3. Legal frameworks

The legislation that is relevant to decisions around storing, sharing and facilitating access to electronic health records and the use of record data includes:

- the UK Data Protection Act, 2018 that embodies the EU General Data Protection Regulation (GDPR),

- the Freedom of Information Act,
- the Mental Capacity Act (including devolved nation equivalents). Further information is available in Appendix 1.

Psychologists need to be aware of their responsibilities under the General Data Protection Regulation 2018 (GDPR). All personally identifiable data held about a service user in an electronic record, email or document, is subject to these regulations, even if pseudonymised. This includes clinical notes held on an electronic record system, emails relating to a service user, supervision notes (even if on paper), process notes, photos and social networking exchanges.

Service users have the legal right to access their EHRs. Practitioners need to carefully consider whether there could be exceptions to disclosure, for instance, if the information may cause harm to the service user, or the information held can reveal information about another person who has not consented to the disclosure.

If there is statutory duty to share information, e.g. a court order, it is important to ensure that only what is requested is shared – with suitable caveats – and irrelevant information (i.e. information not relating directly to the request) is removed prior to sharing. Additional considerations need to be exercised about sensitive information such as sexual or reproductive history. As the service user is the owner of their health record, so a service user with competence (as determined by the practitioner) is ultimately responsible for any consequences regarding requests for sharing their own health record with any third-party practitioners.

4. Information Governance

Psychologists should make, keep and disclose information in records only in accordance with national policy and legislation, and the policies and procedures of the organisation(s) they are employed by or working in collaboration with.

Systems that are explicitly designed and manufactured to provide electronic information for health or social care purposes are subject to two **Clinical Safety standards**. SCCI0129 sets out clinical risk management requirements for manufacturers of health IT systems and SCCI0160 requires a health organisation to establish a framework within which the clinical risks associated with the deployment and implementation of a new or modified health IT system are properly managed under section 150 of the Health and Social Care Act 2012. This applies equally to those in private practice as well as in the public sector.

The NHS and other healthcare organisations are responsible for ensuring that all EHRs comply with the manufacturer's requirements and conducting their own internal Clinical Safety evaluation. Independent practitioners are strongly advised to be mindful of safety issues when using any system or process to record service user information, e.g. an Excel spreadsheet. Independent Practitioners must satisfy themselves that the clinical risks of deployment of the EHR have been reduced to as low as possible – for example considering how service user care is conducted if the power fails.

Psychologists have a responsibility to ensure that their use of health IT systems is clinically safe, and that they comply with any mitigations identified by the manufacturer or by their organisation to reduce any risks associated with use of the system, to as low as reasonably practical.

Many of the governance requirements relating to paper records apply to EHRs, for instance, the potential impact of the information on all who may have access, including the service user, other professionals, managers, authorised carers, etc. Where possible, distinctions should be made between fact, observation and opinion. Judgmental comments should be avoided.

Irrespective of format, records made, kept or accessed by psychologists should be:

- systematic;
- appropriately detailed;
- in clear language/format;
- accurate;
- up to date; and
- relevant to professional work and to the purpose for which they were collected.

It is good practice for service users to be given feedback on the content of their records. Sharing records with service users supports a collaborative approach and enables full and effective involvement. Service user access to records is restricted to information about themselves alone and does not include access to third party reports. Restrictions also apply when disclosure would place the clients or others at risk of serious harm. In tripartite arrangements involving an employer, access to information should be governed by explicit agreements about what information can be shared with the commissioning organisation.

The individual applied psychologist practitioner makes their own judgement, in consultation with local information governance managers, whether it is in the interests of their client not to proceed in accordance with the official positions and protocols. As with any other clinical professional decision made by practitioners, they may be called upon to account for their action. This will include ensuring informed consent if possible, about the consequences of the decision.

Appendix 2 provides a checklist for clarifying if and how to store clinical material outside of an EHR.

4.1 Storage and sharing

It is the working assumption of many of those designing and managing EHR systems that all information will be entered in the EHR, including digitised or scanned copies of paper documents and that the originals can then be destroyed. This is referred to as a ‘paperless’ model. Some organisations may permit the storage of some paper records (‘paper light’). Given the access limitations of paper records, the amount of space required for storage and the cost of storing and maintaining paper records (to meet the requirements for such retention), some services may also choose to digitise their record archives. If digitisation is in the form of a scanned copy of the record, it is important to ensure that some form of indexation is introduced so they can be searched. Other forms of digitisation, such as using optical character recognition (OCR) leading to an editable copy of the record, facilitate detailed searches and more efficient retrieval although errors can arise more readily in such processes and such documents need to be checked for errors.

Cloud based storage is now widespread and is used by most EHR systems. Such storage is generally more secure than on site local equipment (e.g. on one computer hard drive), more resilient and accessible from a range of devices. Psychologists and services should be aware that cloud systems require broadband or 4G internet connections for access, which are more prone to failure than the EHR system and which require special arrangements to mitigate potential interruptions. Reputable EHR companies will assure robust continuity provision of record access in the event of a failure of their systems.

Thanks to cloud storage and fast processing systems, access to vast amounts of clinical information is relatively easy. However, with this much data it can be difficult for clinicians to find timely relevant information and to interpret and integrate it into their daily practice to benefit their clients and service users. The range and quantity of information that could be generated can lead to ‘information overload’ with the challenge for clinicians becoming how to access clinically relevant information rather than having all the information to hand. Psychologists are well placed to assist with the co-production of such systems.

Because cloud based information is networked, there is risk of unauthorised access both within service settings and through hacking or overcoming security arrangements designed to protect confidential clinical information. One of the potential problems with this is that once a practitioner can log into a system, they could potentially have access to the records of other service users, even if access is audited or is restricted to team-based practitioners. The ‘right to know and need to know’ principle governing record access should apply. Consideration needs to be given to ensuring all software is up to date to reduce the risk of viruses or hacking.

It is the duty of health and social care organisations to store direct care information (clinical and social care, and public health activity relating to individuals[6]) securely and to share it according to clear guidance as expressed in the revised Caldicott Guidelines relating to information governance. The newer guidance makes clear the right of service users to access their own records. The NHS Constitution[7] enshrines certain rights to the individual including the right to be informed how their personal information is used and to exercise control over the sharing of that information beyond their immediate care needs, except in certain legally specified circumstances. It is the responsibility of organisations to induct practitioners into the proper use and sharing of record content: at the same time, it is incumbent on practitioners to ensure they are aware of existing and developing guidance and requirements.

EHRs have transformed the landscape of record keeping from a private arrangement between a service user and a Health Professional to a potential contribution to databases used for a variety of purposes including information sharing with other agencies, research and ‘big data’ applications[8]. A great advantage of EHRs is that information may be shared quickly amongst appropriate professional staff and other agencies. Indeed, numerous national safeguarding inquiries have referred to the unfortunate consequences of failure to share information between professionals and/or agencies. This benefit is also the biggest challenge to the clinical process because services users, families, carers and staff may have concerns about confidentiality, security and the ease of sharing information that might be inaccurate.

Whilst the BPS commends the general principle of information sharing in the interests of safe clinical care, it recognises that there will be situations, particularly in mental health services, HIV/AIDS services[9], general hospital work, and in services for sexually transmitted diseases, in which the psychologist and/or service user may not wish to share some or all information electronically, or at all.

When making decisions on such matters, psychologists should consider:

- the wishes, needs and interests of the individual service user;
- service policy, input from the organisation's clinical information or equivalent officer (CIO or Chief CIO);
- the risks of sharing or not sharing information;
- the risks of storing and not storing information;
- seeking the advice of their organisation or Trust's Caldicott Guardians.

Psychologists should satisfy themselves that there are appropriate secure arrangements such that access to records is formally audited, monitored and safely controlled.

Encryption standards are detailed on the NHS Digital website[10] which maintains up to date guidance. These cover the standards of encryption for data at rest (i.e. located on a device such as a PC, laptop or data stick) and data in transit (e.g. email). In essence, all patient identifiable data at rest should be encrypted and all patient identifiable information in transit should be encrypted end to end. Passwords should be secure, changed regularly and not written down.

The Information Commissioner Office website contains practical guidance, updated regularly, on how to deal with data breaches. Should a breach occur the circumstances need to be investigated and procedures modified accordingly, those affected informed directly and consideration given to reporting the breach to the ICO.

Some organisations may provide therapy or assessment services to a member of their own staff. Managing such records requires special consideration because it is unsafe clinically to seal or password protect records (see section 4.3 below), especially if a multidisciplinary team is involved in care. Staff records should therefore be monitored regularly for unauthorised access and steps taken under disciplinary procedures should such access occur. EHRs have the facility to flag or provide an alert in the event of unauthorised access, for instance where a service user is not referred to the staff member.

4.2 Specialist material

Some psychological activities involve the use of information which requires specialist interpretation skills, such as the results of psychological tests. Whereas this information used to be secured against general access and possible misinterpretation, there is now a shift in practice towards making such information available. The use of a virtual 'sealed envelope' is no longer considered to be clinically safe practice (see section 4.3 below). Indeed, some raw test data may be clinically important to share to reduce risks, and this shifts the responsibility of proper use and interpretation of test data to whomever uses it: it is the user's responsibility to work within the bounds of their expertise and competence to interpret the data.

Access to the actual test forms themselves raise additional legal issues. Test materials are often purchased by an individual applied psychologist, and in so doing they enter into a legal contract with the publisher, which usually involves copyright and intellectual property law. The Society encourages psychologists to pay attention to those conditions and use professional judgement when determining how to manage materials such as test forms. Currently, many test publishers require written permission before a test form can be reproduced or scanned; that electronic access is limited to persons qualified to use the test; and that the test material is otherwise kept out of the public domain. This might be achievable for example, if a psychologist in private practice manages their own electronic storage system, but for many who work in a large organisation, it would not.

A consequence of the present situation is that many clinicians will have completed paper test forms that cannot be entered into a service user's EHR. If the psychologist has a strong clinical reason to retain the original paper form, then provision for this needs to be arranged with their employing organisation. However, in many situations, the legally preferable and most practical solution will be to treat test forms in the same manner as process notes (section 4.3), whereby the raw data and other relevant information such a notes made on the form are transcribed into the EHR (in an interpretative report or table of data), and the original form is destroyed.

4.3 Process notes and 'Sealed' sections in the Record

Some psychologists and psychology services have a tradition of retaining notes that are not stored in the primary clinical record (commonly the paper case notes), although they may well be stored elsewhere, such as in separate, secure psychology files. Such material is referred to as process notes and might include, for example, a service user's own often highly sensitive personal comments, written observations, drawings and charts as well as clinician hypotheses and formulations.

Keeping process notes, if the information they contain is not immediately made part of the clinical record, should be contingent on the practitioner having considered the risks of such information being inaccessible to others involved in the care of that individual. The Society advises that it is not appropriate to have a separate 'process' file maintained on a long-term basis and that any such material should be kept for specific, justifiable reasons, such as for use in supervision, and for a finite period. The notes should then either be scanned into the electronic file with the relevant information incorporated into a psychology report or destroyed if no longer relevant. This is partly because of clinical risk consequences and partly because of potential legal issues.

Not every piece of writing about the service user will necessarily be stored: the decision to do so, or not, is up to the individual clinician, having regard to the relevant specific circumstances and the attendant risks. Whatever other conditions might apply, such notes and records should be regarded as part of the clinical record and, if retained, kept securely and not removed from the service premises without appropriate secure arrangements.

If there is a facility for the service user to request the 'sealing' of sections of their electronic process notes, then similar conditions apply. The client must be informed of the potential risks of closing off access, and the psychologist must agree that sealing is appropriate, having considered the risks of so doing and having taken advice from Information Governance leads and their Caldicott Guardian as appropriate. The psychologist must consider the clinical safety risks arising from the presence of a sealed record and ensure these are mitigated (see BPS Document: *Practice Guidelines* for further information).

Psychologists may wish to consider only keeping formal notes and taking care to ensure that speculative or provisional material is clearly identified.

4.4 Diagnosis

EHRs contain or have fields expecting information about psychiatric or other medical diagnosis, this being a vital part of many healthcare records. Some psychologists may use these diagnosis fields whilst others may prefer not to. Provision is now made in all Electronic Health Records for formulations as a standard record feature and is available for use by psychologists.

4.5 Special populations

In managing EHRs appropriately, the practitioner psychologist should be aware that, in some circumstances, standard processes of consent and confidentiality may not apply with certain service user and client groups, for example service users who may lack capacity. Additional guidance regarding consent and confidentiality is available in BPS Document: *Practice Guidelines.*

5. Validation of notes

EHRs do not have a consistent way of allowing ‘counter signing’ of notes. Usually the function of validating or confirming an EHR note is to prevent future editing of the note. The responsibility for the accuracy of the note lies with the individual making the note. The Society recommends that Trainee or Assistant psychologists with a first degree in psychology are not required to have all their entries into paper or electronic records validated by a fully qualified practitioner, e.g. a note to say an appointment has been changed. At the same time, it is the Supervisors’ responsibility to ensure that Trainees and Assistants have their notes audited regularly and in line with their experience and competence. Supervisors must ensure that those they supervise are adhering to good practices in reporting clinical and related activities and that trainees and assistants draw their supervisors’ attention to complex or problematic notes. Where countersignature is official policy, the issue should be raised with the Trust Caldicott Guardian. Further information is available in Appendix 1.

6. Training and psychology service implications

Psychology training programmes should ensure that all trainees are familiar with the use of these digital technologies and can understand the use of EHRs through their formal teaching and placement supervision.

Training should cover the nature and accuracy of record content and the fundamental role of records as an integral part of providing psychological services, as well as wider health and social care. Accurate recording of clinical concerns, assessments, formulations, interventions and outcomes should be integral to psychology training and practice. Trainees should learn that information needs to be psychometrically robust and sufficient for the multiple purposes it will be used for, such as supporting psychology practices and the evaluation and commissioning of psychology services. There is also a need for trainees to develop an understanding of the strengths and limitations of structured records and free text, the use of standard terminologies and the items characterising psychology practices and outcomes.

Psychology departments and services should ensure that staff have proper training and experience. This includes issues of confidentiality, cross-agency sharing, client access rights and accuracy of content. There are clear protocols covering key areas such as those highlighted in these guidelines. Where protocols are being developed by psychology services, it is important for the service to engage with the Caldicott Guardian, where available, from the outset to ensure that the approach taken by the psychology service aligns with local information governance processes.

Principles and practices relating to EHRs and healthcare informatics should be part of continuing professional development. There is a rapidly emerging discipline of Healthcare Informatics, with specialised training being established in the NHS. Psychologists should participate in such training so that the contributions of psychology to this discipline, and the contributions of this discipline to psychology practice, can be properly exploited.

7. Use of EHRs for research

Data held in EHR systems are recognised as a major source of information relevant in many domains of healthcare. Databases derived from these records on a very large scale – ‘big data’ – are being made available for research in the belief that such information will lead to fundamental insights into many health conditions, their origins and treatment. Psychological data on such a scale can produce similar benefits. These data sets, and those on a more modest scale, are subject to the same research standards as any other data set, requiring ethical approval, informed consent, confidentiality and approval of the relevant research bodies. Similarly, EHR data may be made available for audit purposes and is subject to the relevant audit standards.

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Glossary

Algorithms – are the instructions (usually computer programmes or software) for undertaking specific tasks.

Anonymised – data/records are where the normal personal identifiers have been replaced by artificially-created identifiers. The identity of the individual cannot be recovered.

Artificial Intelligence (AI) – involves the simulation of human intellectual skills and processes commonly by computer systems and can involve machine learning, reasoning, rule use and self-correction.

Big Data – extremely large data sets that may be analysed to reveal patterns, trends, and associations; this could be about treatment responses or human behaviour and interactions.

Cloud Storage/Systems – storage and/or processing of information off-site on remote computer systems. These may simply hold data and provide them as needed or they may also process such data and transmit the outcomes to the practitioner.

Digitised Records – Scanned-in copies of the clinical notes or documents such as letters, reports, drawings, completed psychological or other test forms relating to a service user. Digitised records are commonly stored as images whose contents, unlike those of the EHR, may therefore be more difficult to search and process. Some documents may be derived from optical character recognition (OCR), where a computer 'reads' a document and creates an editable form.

Electronic Health Record (EHRs) – a record relating to an individual service user commonly detailing a unique identifier such as NHS number, other demographic information and information about the clinical features, activities and outcomes relating to that individual. The record may be held on a local system in a private practice or a variety of government systems including those of the NHS and Social Care. Services may implement systems aimed at paperless records or may allow some associated records to be retained on paper.

Electronic Health Record (Software) Systems – computer systems designed to capture, store and process individual service user health-related data. Examples include RiO, PARIS, SystmOne, EMIS. While some systems may be generic, they tend to be context specific, e.g. RiO for mental health. These can capture data from a variety of devices including desktops, laptops, tablets and mobile phones, as well as wearable or remote sensing devices.

Primary Care Record (PCRs) – details of the service user's care held by their General Practitioner. These details may be either held electronically or on paper or both.

Primary Care Psychological Care Records (e.g. IAPT) – EHR systems such as IAPTUS (Improving Access to Psychological Therapies System) or PCMIS (Patient Case Management Information System), designed specifically for talking therapies.

Process Notes – a detailed, sometimes speculative, clinician's record of clinical sessions.

Pseudonymised data/records are where the normal personal identifiers have been replaced by artificially-created identifiers. These conceal the identity of the individual but enable the identity to be decoded through separately and securely stored identifiers.

Service user – For the purposes of clarity, this document uses the term ‘service user’ to refer to the person who is the subject of the record.

Summary Care Record (SCRs) – contains selected data from the Primary Care Record intended for secure remote access in special circumstances, for instance to provide emergency care clinicians in a hospital for instance with information about service user clinical needs.

Appendix 1 – Useful links

Adults with Incapacity (Scotland) Act 2000
https://www.legislation.gov.uk/asp/2000/4/contents

BPS Practice Guidelines
https://www.bps.org.uk/news-and-policy/practice-guidelines

Caldiott Guardians
https://www.ukcgc.uk/

Code of Ethics and Conduct
https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct

Freedom of Information Act
https://www.legislation.gov.uk/ukpga/2000/36/contents

General Data Protection Regulation
https://gdpr-info.eu/

Health & Care Professions Council (HCPC)
http://www.hcpc-uk.co.uk/

Electronic Health Records. Post Note Number 519.
http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0519

Mental Capacity Act (2005):
https://www.legislation.gov.uk/ukpga/2005/9/contents

Information Commissioners Office
https://ico.org.uk/

GDPR
https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/

Professional Records Standards Body
https://theprsb.org/

Appendix 2 – Managing confidentiality within Electronic Health Records

Throughout there is a presumption that the default clinical record will be electronic except in specific, governed, transparent situations. Within the electronic record it is recognised that certain services may be sealed off from mainstream services – for example sexual health. Where exceptions have to be made, the following questions should help clarify local arrangements; they should be worked through with local management with the advice of others in Information Governance and if necessary the Caldicott Guardian.

1. Does the local service have an overarching policy about this reflecting the nature of the service and clinical risk issue (as might be the case in a forensic setting)?
2. If there is no such policy, consider what material may be stored outside of open access, with a summary contained in the main record? Examples for consideration include:
    - Detailed process notes from psychological therapy.
    - Trainee process notes.
    - Psychometric test material.
    - Sensitive material, for example details of childhood abuse.
    - Where client requests this, for example where their alleged abuser is also a member of staff.
3. Who does the psychologist check with locally about this if this requires clarification, recognising that the individual practitioner should not make unilateral decisions within a wider organisation and must always consult with their Information Governance lead and Caldicott Guardian?
4. Consider the options for storing such material outside of the main record, for example:
    - Password protected.
    - ‘Sealed envelopes’.
    - Paper record.
5. If paper records are kept, consider where they are stored, who has the access details in case the clinician is not available, and what are the retention policies?
6. If electronic documents are password protected, who has a record of the password and is able to access the document if the clinician is not available?

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REP125/03.19

University College London   Doctoral Course in Clinical Psychology

Client consent form for taping of clinical sessions

Information for clients

Your therapist is a trainee Clinical Psychologist. They are based in the NHS and also registered with University College London (UCL), undertaking a Doctorate in Clinical Psychology.

As you know, your psychologist's work with you is being supervised by an experienced NHS Clinical Psychologist. One way of improving the quality of this supervision is to tape-record sessions. Listening to a tape gives supervisors a much more accurate idea of what is happening, and in this way helps your psychologist to help you.

Unless your psychologist explicitly indicates otherwise:

- tapes of your session will only be listened to by your psychologist's supervisor
- tapes will only be used for the educational purpose of supervision
- recordings will be deleted once their educational purpose has been completed

Some clients find it very helpful to listen to a recording of their sessions. You may wish to have a copy of the tape for yourself. If you would like a copy, discuss this with your psychologist.

On occasion trainees may wish to use tape recordings to help them write clinical reports. If this is the case this will be discussed with you, and you will be asked to complete a separate consent form.

	Please tick
I understand that I am not obliged to give consent, and that if I do not want to this will not affect my treatment	
I agree to the tape recording of my sessions	
I understand that the tape recording will used for the purposes of supervision and education	
I understand that the tape recording will be deleted once its education purpose has been completed	
I understand that I can ask for a copy of the tape	

Name and signature of trainee psychologist:

Name and signature of client:

Date:

The
British
Psychological
Society

Professional Practice Board

Working with Interpreters in Health Settings

Guidelines for Psychologists

October 2008

Contents

Prepared by **Professor Rachel Tribe**, University of East London & **Dr Kate Thompson**, University of East London & North East London Mental Health Trust in consultation with a number of language interpreters and service users.

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

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Executive summary

Working effectively with interpreters should be a skill which every psychologist possesses. This is to ensure that equal opportunities are upheld and that certain groups are not denied access to psychological services. To achieve this aim, all psychologists should receive training in working with interpreters as a core part of their professional training. If this is not available within your trust, it is recommended that this is undertaken as part of your ongoing continuing professional development. Training courses are available in much of the country. These good practice guidelines give an overview of the issues psychologists need to consider when working with interpreters to ensure that they are able to be as effective as possible.

Key recommendations for practice

- Undertake a language needs analysis for the population which your service covers and consider how you will best meet this need.
- If you have not undertaken training in working with interpreters, undertake a training course, If this is really not feasible as you will be working with an interpreter unexpectedly, read the guidelines and allocate time to consider the issues or discuss them with a more experienced colleague in advance of your first session with an interpreter. Psychologists should consider attending deaf awareness training run by their NHS trust in advance of working with a British Sign Language Interpreter (BSLI).
- Check that the interpreter is qualified and appropriate for the consultation/meeting.
- Allocate 10–15 minutes in advance of the session to brief the interpreter about the purpose of the meeting and to enable them to brief you about any cultural issues which may have bearing on the session.
- Be mindful of issues of confidentiality and trust when working with someone from a small language community (including the deaf community) as the client may be anxious about being identifiable and mistrustful of an interpreter's professionalism.
- State clearly that you alone hold clinical responsibility for the meeting.
- Create a good atmosphere where each member of the triad feels able to ask for clarification if anything is unclear and be respectful to your interpreter, they are an important member of the team who makes your work possible
- Match when appropriate for gender and age, do not use a relative and never use a child.
- Be aware of the well-being of your interpreter and the possibility of your interpreter suffering from vicarious traumatisation; consider what support they will be offered.
- At the end of the session allocate 10 minutes to debrief the interpreter about the session and offer support and supervision as appropriate.

- All written translations used should have been back translated to ensure they are fit for purpose.
- Extreme caution should be exercised when considering the use of translated psychometric tests.
- Commissioners need to ensure that there are clear pathways to support for all members of their local community including those who do not speak English.

Introduction

Avoiding discrimination by ensuring equal access to psychological therapy to non-English speakers must be a fundamental aim. Working with an interpreter and communicating through a third person can feel like a challenge and it may require enhancing your repertoire of skills as a psychologist. However, there can be definite gains in developing your skills in this area. For example, working with an interpreter may assist with learning about different views of psychological well-being, forms of client presentation, idioms of distress, explanatory health beliefs and world views. Becoming skilled at working with an interpreter will also enhance service delivery through ensuring that access to psychological services is not limited to those fluent in the English language, irrespective of need.

Language is a multifaceted, rich and complex phenomenon which forms one of the cornerstones of human communication and should be accorded particular attention in providing client services. Interpreters are often not recognised for the unique skills and expertise that they can contribute in enabling psychologists and clients/service users to communicate with one another. Working with deaf clients who use sign language as their first language likewise requires specialist skills due to the need to consider a visual language rather than a spoken language.[1]

It is essential to consider the context when working with an interpreter. Being unable to fluently speak the language of the country you are currently living in or having difficulties with hearing can be frightening and disempowering experiences. Racism and power differentials can also play a role and appropriate provision for all clients needs to be considered in providing interpreters.

It is good practice to offer all clients whose first language is not English the option of using an interpreter. Otherwise, individuals may not realise that they can have a professional interpreter and may try to manage without one, creating difficulties in communication. At the same time, it is important to recognise the difficulties many non-English speaking clients can have in using interpreters for fear of breaches of confidentiality, especially where the interpreter might be from the same community-based ethnic group. Thus, it is crucial to offer a choice about interpreter and to find ways to explore this choice with your

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[1] It may also be useful to invite clients to attend sessions with other people who might aid their communication abilities, for example clients with learning disabilities, aphasia or dysarthria might benefit from attending sessions with a support worker who is more familiar with their style of communication and can offer clarity to the clinician.

clients, weighing up the need for clear communication against any other competing considerations.

A multilingual appointment card can be downloaded from www.harpweb.org.uk . In the case of deaf clients, it is equally important to ensure that appropriately trained sign language interpreters are made available.

The guidelines are divided in to 12 sections for ease of reference. A number of references are interspersed through out the text, so that the interested reader can follow up these points if they so wish.

These good practice guidelines provide some working principles to help inform and direct practice. They do not, however, attempt to cover every eventuality which may occur when working with an interpreter. The reader may need to refer to these guidelines in conjunction with the underlying Society and divisional professional practice and ethical guidelines.

The exact relationship between language and meaning is still contested. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level (Anderson & Goolishian, 1992; Burr, 1995; Mudakiri, 2003) and this should be kept in mind when working with an interpreter. The psychological relationship between a person's first language and a second or subsequent language is also an area of debate (Antinucci-Mark, 1990; Antinucci, 2004). This may carry particular resonance when working with interpreters and this should also be considered.

When working with deaf clients it is recommended that the clinician should educate themselves about deaf culture and deaf identity through a local deaf awareness programme (either within a NHS Trust or externally). Deaf people's experiences of spoken language may have been influenced by the way they were educated, their family background, whether they learnt sign language as a child, or whether they were encouraged to use their voice and to lip-read (often called an 'oralist' approach). It must also be remembered that around 90 per cent of deaf people are born into hearing families.

Similarly, it is helpful for psychologists to seek to educate themselves about the cultural background of a non-English speaking client both through their own research and through exploration with their clients and interpreters. This may be particularly pertinent when working with survivors of persecution and violence. It is important to be mindful of the way in which power differentials originating in the country of origin may affect the relationship between psychologist, interpreter and client, particularly in the light of political and social conflict.

It is also important for service providers to consider the ways in which they might support the interpreters they use. As Lipton et al. (2002) point out, interpreters may work with seriously traumatised clients, with possible psychosocial consequences as a result. Few have had a comprehensive mental health training which would cover such topics as boundaries and self-care, and may thus be very susceptible to vicarious traumatisation (Tribe & Morrissey 2003). Further, interpreters frequently find themselves obliged to convey very difficult information to clients, for example explaining that a client is to be detained in a psychiatric hospital, has been given a particular diagnosis or prognosis, or is being given a custodial prison sentence. All these outcomes can have serious or life-changing implications for the client and it may be difficult for the interpreter to handle such a challenging role. Professionals should recall that interpreters are entitled to support in the same way as any other professional colleague and a duty of care applies, whether or not they are employed by an outside agency, and employment responsibilities cover all employees (Management of Health and Safety at Work Regulations, 1999). Suggestions for supporting interpreters and providing adequate supervision are offered in section 7.

The guidelines

1. Relevant guidelines and legislation

There is extensive international and national legislation that advocates for equality of access to health and legal services, although in many instances the use of interpreters is not always clearly articulated. Legal frameworks that advocate for equality of access to health services include:

- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- The United Nations Convention of the Rights of the Child (1989)
- Human Rights Act (1998)
- Race Relations Amendment Act (2000)
- The Disability Discrimination Act (1995) and the Disability Discrimination Act (2005)

There are a number of policy documents that promote equal access to health and some of these specifically mention access to interpreters. Legislation in England includes:

- The National Service Framework for Mental Health, which emphasises the importance of interpreting services across all seven standards.
- The Mental Health Act Code of Practice clearly instructs local and health authorities to ensure that approved social workers and doctors receive adequate guidance in the use of interpreters and to make arrangements for easy access to trained interpreters.

As a general principle, it is the responsibility of the psychologist to ensure effective communication between themselves and the service users.

2. Booking/finding an interpreter

2.1. Language Needs Analysis

Psychological service providers may need to consider conducting a formal needs assessment relating to interpreting services. This might include obtaining baseline data on the language needs of the communities they serve, including British Sign Language (BSL), and a review of the languages used by relevant clinical staff to ensure that they make optimal use of the language resources they have available. They should also consider whether the needs of their population are best served by employing interpreters, advocates or bilingual link workers directly or by using external interpreting services.[2]

When offering psychological services to deaf people it is advisable to have regard to the Disabilities Discrimination Act and the responsibilities under this Act. Local mental health services should contact any of the three national deaf services for advice.[3]

2.2 Locating an appropriate interpreter

As stated, it is a matter for each organisation/service provider to decide whether to employ a team of in-house interpreters and health advocates or use an interpreting agency, ensuring that any interpreting agency meets the appropriate quality criteria and is accredited by the relevant body.

The professional concerned should find out the client's first language and try to book an interpreter who speaks this language, ideally from the same country, and when necessary a speaker of the same dialect as the client. Do not assume that someone who speaks a language can speak/understand it in all the dialects (Marshall et al., 1998; Tribe with Sanders, 2003). (A guide to languages by country can be found at www.ethnologue.com/country_index.asp).

The interpreter should not only be fluent in two languages but have an understanding of the two different cultural contexts (Tribe & Raval, 2003; Razban, 2003). Ideally they should have undergone recognised language testing to ensure that they are fluent and have relevant experience for the task. In Britain, the Register of Public Service Interpreters (www. nrpsi.co.uk), the Institute of Linguists, (www.iol.org.uk) and the National Language Standards (www.cilt.org.uk/standard/languages.htm) would be the organisations to contact and can assist in locating a suitably qualified interpreter.

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[2] Health advocates are employed by many NHS trusts. In addition to language interpreting they are employed to advocate for the individual by ensuring that their needs are understood and met. BSL interpreters and advocates for deaf people are two separate professions.

[3] The three national deaf services for England and Wales are: a) Old Church, Balham, London, b) Denmark House, Queen Elizabeth Psychiatric Hospital, Birmingham, and c) John Denmark Unit, Prestwich Hospital, Bury, Manchester. For more information on working with deaf people in a mental health setting see the NIMHE report *Mental Health and Deafness, Towards Equality and Access* (2005) http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4104006.

In the case of deaf clients, it is important to ensure that the interpreter is registered with CACDP's independent registration Panel (IRP) http://cacdp.org.uk/interpreters/online_directory/online- directory.html)[4] and is a member of the Register of Sign Language Interpreters (MRSLI); they may also be registered with the Association of Sign Language Interpreters (ASLI) http://www.asli.org.uk.

It may also be important to make some assessment of a deaf client's fluency in using sign language. Some deaf people, and perhaps a high proportion of those needing mental health support, may not be fluent in sign language due to the delay in their opportunities to learn BSL. Educationalists have often promoted an 'oral' approach to deaf education, and this has prevented deaf children from learning to sign because of the belief that this will interfere with their ability to learn spoken and/or written English. In reality, many deaf children have been drawn to signing as a natural method of communication in the playground or outside of school. Others, who may have been to a mainstream school, may not have had this opportunity and have consequently learnt BSL as an adult after leaving school, perhaps through attending a Deaf Club. Hence for some deaf people their signing may be not fluent, but this may only be an indication of their particular situation rather than a learning disability or a mental health difficulty.[5]

As a general rule, it is not appropriate to ask family members or other professionals to 'help out' because they appear to speak the same language as the client or have sign language skills. Interpreting is a highly skilled role and not something that any person or even any professional can just slip into (Sande, 1988; Vasquez & Javier, 1991; Pochhacker, 2000). The use of family members also creates difficulties with regard to confidentiality (Juckett, 2005) although some clients may insist upon it. This should be discussed with

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[4] The RNID can also offer support in finding a sign language interpreter for deaf individuals and they can be found at http://www.rnid.org.uk, telephone 0808 808 0123, e-mail: information@rnid.org.uk.

For more information on working with interpreters in British Sign language see http://66.102.9.104/search?q=cache:G1iKfmvdc9UJ:www.aucc.uk.com/journal_pdf/aucc_summer_3.pdf+deaf+interpreters+in+the+mental+health+setting&hl=en

[5] It may be useful to consider working with an experienced deaf communication facilitator (DCF) or deaf relay interpreter as well as a sign language interpreter if the service user's sign language is dysfluent through any significant language delay during childhood or an actual learning disability. A deaf communication facilitator is a deaf person who is a native BSL user, and who has experience of communicating effectively with a variety of deaf people with varying levels of language ability. A DCF will be able to break down complex signed phrases into simpler ones, enabling a deaf service user to understand the concepts being discussed. Working with a DCF will change the dynamics in the room as yet another person is put into the chain of communication between you and the service user. However, this may benefit the service user who may feel more comfortable with another deaf person in the room helping them to be more effectively involved in the communication. This may balance the cultural identities and power differentials in the room with two hearing people and two deaf people.

them. Children, however, should never be used as interpreters as this places them in a difficult and prematurely adult role towards their parent or relative.

If your client refuses a professional interpreter and comes with a non-professional to interpret (even if this is a family member or friend), it is important to make clear to them that they can have a professional if they want, and that you are clear why they might prefer someone they know. Bear in mind in any work that you do with a non-professional that they may not be as skilled in English, or indeed in their native tongue and they may have little or no experience of, or training in interpreting. They may be unclear about such issues as confidentiality, boundaries and the use of good interpreting skills. They may also have their own agenda about the client and wish to tell you more or less about the client than the client themselves would wish (Thompson & Woolf, 2004).

In some cases, using a non-professional interpreter may help you establish an atmosphere of trust or set the scene for some psychological work in such a way that you can then negotiate with the client to introduce a professional interpreter (Thompson & Woolf, 2004).

In many cases individuals may come from small ethnic communities and as a result their interpreter may be known to them from other settings. This can create complications. In the case of deaf individuals, the deaf world is a small one (about 60,000 deaf BSL users in UK) and the sign language interpreter population is even smaller (about 450 to 500 registered in UK), making it quite possible that an interpreter has interpreted for any given service user before. In both language and sign language interpreting work, this familiarity may be acceptable (or even preferred) by the service user. However, it is always important to explore whether the service user and interpreter know each other and whether there are concerns about the level of confidential information that may require to be shared.

Some writers have suggested that it can be helpful to match for gender, age and religion between language interpreters and clients when possible (Nijad, 2003). This can be particularly relevant, for example, in the case of sexual assault or domestic violence or when discussion of taboo areas may be necessary. However, clients can differ in their requirements and it is important to offer a choice and assess individual requirements. This can readily be done at the same time as you ask the client about what language would be most suitable for them, perhaps by sending an easily completed form with their initial appointment letter. It should also be acknowledged that while offering a choice may be the ideal, it is not always possible to ensure this.

In some trusts, there may be pressures to make use of telephone rather than face-to-face interpreting services, although the experience of clinicians would indicate that this form of interpreting has limited value for psychological therapy, or for health-related work in general. Nevertheless, there may be occasions when it is helpful to use telephone interpreting, for example when rescheduling appointments, in crisis situations or when there is a need to establish consent to treatment.

2.3. Training issues

It is argued that the provision of appropriate training for both practitioners and interpreters, as well as the use of effective guidelines can produce improvements in service provision (Tribe, 1999). More experienced interpreters tend to recognise this need, and are more likely to advocate training both for themselves and for the professionals for whom they interpret (Granger & Baker 2003). Baker et al. (2008) note that the same applies to BSL interpreters, although training for professionals working with BSL interpreters has not yet been established. Further, many of the difficulties described when working with language interpreters in mental health seem to arise as a result of inadequate training for both parties. Tribe and Raval (2003) provide a template for a possible training curriculum.

Both interpreters and psychologists require appropriate induction in working together even if an outside agency is providing interpreters. Running appropriate training and information sessions ensures that the interpreters are conversant with the organisation's aims, objectives and culture and may also provide an integrating function. (Kiramayer et al., 2003; Tribe & Morrissey, 2003; Williams, 2005). Joint sessions where professionals and interpreters are trained together allows a better understanding of each person's role as well as the development of a genuine sense of co-working.

3. Preparation before the consultation/meeting

Try to spend some time considering all the implications of working with a third person (the language or sign language interpreter/bicultural worker) before the consultation/meeting. It can be useful to discuss this with an experienced interpreter or, failing that, with colleagues who have experience of working with interpreters.

The service provider should have written guidelines and a contract that interpreters are asked to adhere to and ideally sign. You may need to ensure that your interpreter signs the contract of your organisation or their professional body; this should cover such aspects as confidentiality, roles, responsibilities, ethics and boundaries. For example, it is important that the service user maintains self-determination in the same way as any other service user and all parties should ensure that this is not compromised by an interpreter being involved. In the case of sign language interpreters, there is an established code of conduct which provides guidelines for dealing with ethical issues. However, these guidelines may not include some of the challenging situations that can occur in mental healthcare situations.

It is also important to ensure that an interpreter is fully aware of all issues relating to professional boundaries. For example, does the interpreter know that it is preferable that if they are to undertake a number of therapeutic sessions that they should not interpret in any other situation for the client as it could blur boundaries and might trigger feelings from within the therapeutic sessions and may be contra indicated?

3.1 Changes to the dynamics of therapeutic work

A service user may have anxieties about being dependent on another person, the interpreter, to act as their voice and to explain their emotions. Some clients have reported feeling infantalised by this process (Tribe, 2007). Service users may also have anxieties about confidentiality. Alexander et al. (2004) have noted that the issue of personal trust was seen as paramount by service users in a study examining access to services with interpreters. A psychologist working with an interpreter will need to be aware of this possibility, and to consider how this may impact on their work and how to deal with it.

Working with an interpreter as a conduit also makes you dependent on another person, and this can change the dynamic of the meeting. Clinicians sometimes report feeling anxious in this situation or excluded from the interaction which can feel as though it takes place between the client and the interpreter. Some writers have noted that transference and countertransference reactions can be more complex (Spector et al., 2007): *'Unlike the dyadic clinician–patient model and its single relationship, the triangle clinician–interpreter-patient model involves three relationships. Thus, it is 200 per cent more complex and involves the patient's transference to both clinician and interpreter, countertransference among both of the latter toward the patient, and the co-worker relationship between clinician and interpreter'* (Westermeyer, 1990, p. 747). In fact, it may be that thinking in terms of transference and countertransference is not the most helpful in a three-way interaction and clinicians may find it more helpful simply to reflect on the complex emotional reactions in the room (Miller et al., 2005). There can be a sense of two overlapping dyads (perhaps the clinician and interpreter or the interpreter and client) rather than the three parties working and communicating in a good three-way therapeutic relationship. The best way to manage such developments is to reflect upon them, both in supervision (for the clinician) and in conversation with the interpreter, who may be able to feed back other aspects of the dynamics and may need help in managing or containing these.

When working with interpreters it is important to pay particular attention to the change in the dynamics which the presence of an interpreter can bring. In the case of language interpreters there may be an assumed alliance between the interpreter and the psychologist through sharing a language and a perceived position of power by the client. The psychologist can feel threatened by being in a triad as opposed to a dyad and once removed from the words which are being spoken in the consultation. With sign language interpreters, it is useful to remember that the interpreter is a hearing person, like the majority of psychologists. This may affect the dynamics within the room as there will be two hearing people (with privileged positions in a dominant hearing society) and one deaf person (with a less privileged position and frequent experiences of being excluded by hearing people). Most interpreters will have some awareness of this dynamic, but it is important to reflect on the interactions within the session. Likewise, it is also possible that the service user will be suspicious of all hearing people, and maybe sign language interpreters in particular, perhaps accepting them only as a necessary evil, while there is an additional dynamic of perceived alliance between deaf people and interpreters on the part of health professionals, who may see them as sharing a common language and understanding of deaf culture.

3.2. Language and culture

Oquendo (1996) notes that cultural nuances may be encoded in language in ways that are not readily conveyed in translation. In general, the languages being used need to be thought about and it can be helpful to discuss these issues with native speakers, including your interpreter, in advance of the session. This also makes sense when considering the use of visual components of British Sign Language (e.g. facial expressions, body movements, etc.) and bringing your reflections on this into your consideration of the psychological process of your work.

Similarly, it is helpful to remember that languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language and may not always be directly accessible in another (Antinucci, 2004; Keefe, 2008). There may be no appropriate word in one language for terminology that is commonplace in another. Again, native speakers, including your interpreter, may be able to guide you on this.

In addition, health beliefs and views about emotional well being, as well as idioms of distress and manners of presentation can vary with an individual's cultural and religious background. This can have important implications which need careful handling particularly when working in either mental health or forensic/legal settings (Holt Barrett & George, 2005).

In addition to the factors influencing language and culture, it must be remembered that conversation conducted using interpreters is mediated communication, mediated through an interpreter or through a second language (Holder, 2002), a process that can bring inadvertent changes. Given that interpreters must process the material with which they are dealing through their own subjective experiences, the very act of interpreting shapes the material in some way. This is a highly complex issue, and researchers have understandably encountered difficulties in trying to investigate it (Haenal, 1997; Marshall et al., 1998; Bot & Wadensjo, 2004). The communication can become altered through the mediation of the interpreter in numerous ways. One example might be when an interpreter takes it upon his or herself to interpret only part of what is said, summarising the gist for the clinician, or alternatively when a clinician has failed to explain the use of therapeutic techniques, making their style or choice of questioning hard to translate (for example, the use of circular questioning, reflective summarising, etc.). Such actions are usually an indication that the psychologist and interpreter have not had a meeting in advance of the session to clarify their roles and the stance required of the interpreter (Freed, 1988). Furthermore, the way different languages are constructed may mean that certain phrases spoken by the psychologist in English cannot be translated exactly by the interpreter to the client, thereby potentially altering the intended meaning of the initial phrase. It is important to explore with the interpreter what it would be most appropriate to do in such instances.

4. Practical considerations

The implications of using mediated communication need to be considered prior to any meeting with a client. For example:

- Remember the meeting may take longer when working with an interpreter and consider allocating additional time in advance of the meeting (Cushing, 2003; Tribe & Morrissey, 2003).
- Avoid using complicated technical language. Psychology has its own abbreviations and language, so remember that the interpreter is unlikely to have undertaken training in psychology in either of the languages used. Some medical and legal agencies find it useful to have a specialised medical or legal dictionary available. (Tribe & Morrissey, 2003).

- Words and signs do not always have precise equivalents, and a short sentence in English may take several sentences to explain in another language or vice versa. Do not become impatient if the interpreter takes longer to interpret than you would have expected. (Tribe with Sanders, 2003).
- Be wary of using proverbs and sayings. If something does not make literal sense, it is usually best avoided. That said, in some cases the use of a proverb in the client's language, or your use with them of an old English saying to illustrate something, can be very powerful in your work. This needs careful handling to make sure that the concepts have truly been understood by all parties.
- Clinicians should also be aware that it can become easy to lose concentration or to lose the thread of the session as the pace becomes slower and perhaps disjointed, given the space needed for interpretation.

If you are going to see the client for a number of sessions, try to use and book the same interpreter throughout to encourage rapport and build trust in the relationship between client, interpreter and clinician. This will make the whole process flow better, be more containing for all the participants and is likely to lead to better outcomes (Raval, 1996). A client's request to change the interpreter should be explored within the work and accommodated whenever possible. Thompson and Woolf (2004) helpfully suggest giving the client a form at the end of the first session so that they can confirm whether they are happy with the interpreter. (They can take this away, fill it in and send it back to you.) Most people can find someone to translate the form or understand a little written English and this allows them a say in whether to proceed with the interpreter offered.

Consider the layout of the room and the positioning of chairs before the session starts. In spoken language interpreting work, a triangle usually works well as the parties are equidistant and the interpreter is accessible to both the clinician and the client. In some cases, however, clinicians prefer the interpreter to sit behind the client and literally become their voice, taking a lower profile in the session (Cushing, 2003). While this is a matter of personal preference, it is important to be clear that wherever the interpreter sits, they are an active part of the therapeutic triad, and cannot be considered as a simple mouthpiece.

In sign language interpreting, it is good practice to sit next to the sign language interpreter, and opposite the service user so that eye contact from the deaf person is easily shifted between you and the interpreter. The room should be well lit with few visual distractions or bright lights that can make watching signed communication (e.g. face, eyes, hands and upper body) a strain. The ASLI should be able to advise on this.

It is important to make interpreters feel at ease and ensure that they have the best opportunity to use their language skills and cultural understandings in the service of the client (Tribe, 2005). You may wish to consider how you will do this. For example, at your initial meeting with an interpreter you can convey to them your willingness to listen to any suggestions or ideas they may have about the client. This needs to be conveyed in such a way that you make clear that you have clinical responsibility for decisions about your client's care, but welcome input nonetheless. A warm and supportive atmosphere between clinician and interpreter is likely to facilitate the therapeutic relationship for the good of the client and your work together.

Some interpreters use the first person when interpreting (saying 'I' when responding with the client's words) while others feels more comfortable to use the third person. Some authors have suggested that it is preferable to use the first person, giving a more accurate rendition of the words and emotions being expressed and conveying a better sense of immediacy (Tribe, 2005). In practice, most interpreters move between the first and third person, and it can be revealing to keep a check of this and reflect on what might be happening in the therapeutic situation to lead to such switches. If you have a preference, however, you may need to discuss this in advance with your interpreter and see what their stance is on this issue.

It is important that you create an environment where the interpreter feels able to ask for clarification if he or she does not understand what you are saying (Abdallah-Steinkopff, 1999). This can be encouraged through having a briefing session prior to the clinical consultation and leaving additional time for reflection at the end of each session. Your language interpreter is not only proficient in two languages but may be a very useful source of information about the country the client is from, the culture, the politics, the geography, the symbols and meaning relevant to the society or to particular ethnic groups, etc. It is good practice to make full use of the resource of your interpreter, something only possible if he or she is fully able to make sense of what you mean.

Baker et al. (2008) note that this is also true to a limited extent for sign language interpreters, noting that using the interpreter as a resource should only be done with caution. Most SLIs are hearing people and as such cannot share the deaf culture in the same way as a deaf person. If they are related to a deaf person (i.e. sibling or parents are deaf) then there may be transference issues present. The ideal, as noted by Baker et al. (2008), is to use a deaf communication facilitator or relay interpreter who can provide the cultural knowledge and experience described above, which may then be discussed with the interpreter. Currently deaf communication facilitators are not commonly used, and present an added dynamic which may also be unusual for a sign language interpreter to work with.

5. Preparation with the interpreter

It is rare for interpreters to have had previous training or experience of mental health work or indeed to have worked in the same speciality as the clinician. Therefore the clinician should always aim to arrange a pre-session interview with the interpreter. Spend 10 or 15 minutes on the first occasion to establish a relationship, decide how you will work together, explain the objectives of the meeting and share any relevant background information. This is an essential investment. This may also be an opportunity to clarify technical concepts, vocabulary or jargon which is likely to be used, as well as to check whether or not there are any cultural issues likely to bear on the situation. You can also decide what mode of interpreting is to be used, for example whether you will work using the linguistic (word-for-word), psychotherapeutic/ constructionist, health advocate/community interpreter or the bicultural worker mode (Tribe, 1993).

Brief definitions of these four models are:

- The linguistic mode, where the interpreter tries to interpret (as far as is possible) word-for-word and adopts a neutral and distanced position (Cushing, 2003; Tribe, 1998).
- The psychotherapeutic or constructionist mode, where the meaning/feeling of the words is most important, and the interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation (Tribe, 1998b, 1999; Raval, 2003).
- The advocate or community interpreter, where the interpreter takes the role of advocate for the client, either at the individual or wider group or community level, and represents their interests beyond interpreting language for them (Tribe, 1998; Drennan & Swartz, 1999; Baylav, 2003; Razban, 2003). (This model would not normally be provided by BSL interpreters as the roles of advocate and interpreter for deaf service users have been developed as separate roles/professions.)
- Cultural broker/bicultural worker, where the interpreter interprets not only the not only the spoken word but also relevant cultural and contextual variables (Tribe 1998a; Drennan & Swartz, 1999).

Each of the above models of interpreting has their place and will be appropriate in particular circumstances

6. During the meeting/consultation

The client may initially be uncomfortable with an interpreter being present, perhaps because of concerns about confidentiality and information reaching other members of their community, or they may be embarrassed. It may help to explain at the beginning of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency and their professional body. You may also wish to explain the limits of confidentiality which relate to your place of work, for example the need to report active suicidal ideation, etc. (Tribe with Sanders, 2003).

Clients can put interpreters under considerable pressure to take on additional roles, for example to become involved in advocacy on their behalf, etc. Making clear issues of accountability and explaining the role of each party and the limitations of their responsibility assist in containing such pressures. (Tribe & Morrissey, 2003, Razban, 2003).

Look at the client as much as feels natural, rather than at the interpreter unless speaking specifically to the interpreter. In general we tend to move our eyes in a natural way between speakers but it is important to be aware of the three-way relationship and make sure that the client does not feel excluded. If your client has hearing difficulties, as stated above, it is important that you use your body positioning and eye contact to facilitate communication as much as possible.

When working with deaf service users, it is best to maintain eye-contact with them so that your communication is visually self-explanatory, although if eye contact is maintained for too long, especially during a 'silence', the deaf person may feel that they are expected to talk as mentioned above. Appropriate eye contact is essential from the therapist and interpreter. Try to resist any temptation to talk to the interpreter, unless you are explicitly addressing them. When the interpreter is signing, try to maintain eye-contact with the service user rather than the interpreter. It often helps to speak only when signing has stopped so that everybody to be clear about who is communicating, lessening the demands on the sign language interpreter.

You may need to adjust the pace of delivery and break your speech into shorter segments, because the interpreter has to remember what you have said, translate it and then convey it to the service user. If you speak for too long, the interpreter may be hard pressed to remember the first part of your speech. Conversely, if you speak in short bursts, you may find that your speech becomes fragmented and you lose the thread of what you are saying. You will find that with open communication and trust a natural rhythm becomes established, with which everyone feels comfortable (Razban, 2003).

Similarly, try to avoid discussing any issues with the interpreter that do not require interpretation. This can make the client feel uncomfortable and excluded. If such issues do require discussion, get the interpreter to explain this to the client, or discuss these issues with the interpreter once the client has left (Razban, 2003; Baylav, 2003).

At the end of a session, a summary of what has been decided and clarification of the next steps can be useful. It can also be helpful to review the session, including reflection on what the experience of having an interpreter present was like. The interpreter's views should be sought by the clinician and also translated for the client's benefit.

7. After the consultation/meeting

When the session is finished you may need to sign the interpreter's time sheet if they work for an external agency. Interpreters often prefer to leave after the client so that they do not feel pressurised to get involved in a personal relationship or in helping or acting as an advocate for the client in other situations. Showing the client out and then signing the form can facilitate this. It also offers a structured opportunity and some time for debriefing.

Schedule 10 minutes with your interpreter after the session to review how you worked together and any other issues relevant to the session (if the interpreter is being paid on a timed basis, this time must be included). This time can be used to:

- Allow time to ask the interpreter their perceptions of the meeting and to inform you of any cultural factors that may be relevant and that you may have missed. This also allows you to check with them about anything you may have noticed, for example from non-verbal communication or expressions.
- Allow you to ask them about any areas that are unclear to you and which their knowledge of the home country or region, or hearing of the account first hand could clarify.
- Ask the interpreter how it was working with you and whether you could usefully change anything in the way you are working (e.g. pace of speaking, length of speaking).

- Do a structured debriefing – as stated above, it may be hard for the interpreter to debrief anywhere else because of their code of confidentiality. There is often no in-house supervision for interpreters. You may wish to provide the interpreter with some contact details in case they need to de-brief at a later stage about your session, remaining mindful of the risks of distress and vicarious traumatisation that the interpreter might face.

8. Written translations

All written translations should be back-translated (i.e. documents being translated from one language into another by one translator and then translated back to the original language by a different translator, the two versions then being compared). This can appear a costly and time-consuming business but can ensure that the translation is clear and states what it is intended to state. There have been many examples of incorrect and sometimes incomprehensible translated versions of English documents, and it is well worth the additional effort of further checks to ensure your message is adequately translated. This may be particularly important when assessment and/or therapy has occurred and is being reported as a legal case

9. Psychometric tests

Clinicians need to be extremely cautious in the use and interpretation of psychometric tests. Firstly they may not have been adapted for the population from which the client originates. Adaptation includes back translation (see point above) measures of equivalence of construct, reliability, validity and norming. See the International Test Commission Guidelines on Test Adaptation (2000) for a full discussion of this.

Neglect of adaptation procedures would mean that the meaning of any results could be severely compromised (Holt Barrett, 2005).

Rahman et al. (2003), writing about a screening questionnaire for mental health, suggest that key informant interviews and focus groups should usefully be undertaken, as questionnaires may incorporate complex conceptual and construct issues. It has also been noted that psychometric measures may have been designed with one group in mind and that the concepts used may not be applicable to another group. For example, in some African cultures it is more common to communicate distress in psychosomatic terms but elevated scores on a psychosomatic index may convey a different meaning to the one that the client might be trying to convey, which would affect the validity of the interpretation of results.

Extreme caution is also needed when considering using psychometric tests with deaf clients (Cromwell, 2005). Few psychometric tests or standardised assessments have been validated on the deaf population.

10. Telephone interpreting

There is sometimes pressure on psychologists to use telephone interpreting, which can be assumed to be easier to manage, quicker or cheaper. While it may have a role, it is not without its own dilemmas and often does not make things any less costly. Most interpreting agencies charge by the minute or a number of minutes for telephone interpreting and by the hour for face-to face interpreting, making charging by the minute far more expensive.

In some cases it can be helpful to use a telephone interpreter. For example, one advantage is that confidentiality is safeguarded to a higher degree when the interpreter and client do not meet face-to-face. This may be helpful when the client comes from an ethnic group which is very small or they are very embarrassed about needing an interpreter or have an issue which they have difficulty expressing. It can also be helpful for rearranging appointments or other forms of negotiation when face-to-face interpreters are unable to attend for any reason. It is also useful when a client arrives unexpectedly and requires a brief consultation or perhaps an immediate risk assessment or where the need for conveying test results is necessary.

In the main, however, as stated above, mental health work with its complex and relational setting is better conducted with a face-to face interpreter who, like the psychologist, would use the non-verbal communication of the client as a vital part of what they are able to feedback to the psychologist.

Whenever interpreting by telephone is used, a recognised and accredited agency should be employed as provider (see section 2.2).

11. Other issues to consider

Commissioners need to ensure that there are clear pathways to support for all members of the local community including those who do not speak English. Clients need to know how and where to access services if they require them and this should include language support services (interpreting, advocacy, bilingual link work and translated information).

It has also been shown to be advantageous when interpreters are viewed as part of a mental health team for them to be shown appropriate collegial respect and invited to attend relevant departmental, agency or hospital meetings. Although in practice this rarely happens it is worth considering their inclusion when appropriate, as the benefits of gaining the perspective of an interpreter or bicultural worker can be many. Interpreters can contribute to service provision and delivery and they can gain a better understanding of how organisations function and the context of the work they undertake (Raval & Smith, 2003; Tribe & Morrissey, 2003; Raval, 2005).

Information in the client's own language is important and it is good practice to use translated materials whenever possible, particularly for individuals from larger language groups. A multilingual appointment card (downloadable from www.harpweb.org.uk, see page 3 of these guidelines) or translated appointment letters may help to improve attendance rates.

In addition, written care plans should be available in the client's own language.

When providing written information for deaf people (including care plans) be aware that not all deaf people are comfortable with written English. However, there is no alternative written form for BSL. You may need to be creative and use video or DVD to record a signed version of a care plan.

NHS Direct operates a 24-hour nurse-led advice and health information service[5] providing confidential information and details of local health services including doctors, dentists or late-night-opening pharmacists. NHS Direct can provide interpreters when talking to someone who cannot speak English

12. Recommendations for improvements in the future

It is recommended that each psychologist takes individual responsibility for ensuring they are skilled at working with interpreters. This may have training implications both at a pre-professional and continuing professional development level. Lack of experience or skills should not be used to justify not engaging in therapeutic work via an interpreter. No psychologist should be in a position in which they cannot offer equity of service to all potential referrals.

Further, individual clinicians, as well as the organisations that employ them, have a clinical responsibility towards the interpreters that they employ. In this way, opportunities for debriefing must be offered whether by individual clinicians or through supervision groups as appropriate. It is not good practice to leave interpreters without support for their work with mental health clients.

Each organisation or NHS Trust could benefit from developing its own clinical strategy on language support to consider the ways in which interpreting, translation, advocacy and the work of bilingual staff is integrated into the activities of the organisation overall. This should be viewed as an essential piece of work feeding into the overall race equality policies.

An established career structure for interpreters which acknowledges the important contribution that they make would help to ensure that they are adequately recognised and remunerated for the work which they do at the individual and organisational level.

* We would like to thank Clare Shard of the Association of Sign Language Interpreters (ASLI) and the leader of the Mental Health Working group for her comments on these guidelines and the steering committee on test standards.

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[5] The telephone number for NHS Direct is 0845 4647. They also have a website (English only) http://www.nhsdirect.nhs.uk

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SECTION 8 APPENDIX 10: HEALTH AND SAFETY POLICY ON PLACEMENT

All Trusts will have local health and safety policies covering a wide range of measures designed to minimise the risk of harm to employees. Not all of these will apply to the work of trainees, but there are some important areas which supervisors need to cover with each new trainee. These relate to personal safety at work, and it is important that supervisors know that trainees are appropriately briefed and understand the implementation of these policies in practice.

Personal safety at work

Along with other workers in the NHS, Clinical Psychologists need to be aware of the risks of assault from clients. Risk cannot always be prevented, but it can be minimised if sensible precautions are taken.

It is reasonable for trainees to expect that the training programme, the employing Trust, host Trusts, and their supervisors will have:

a) thought about any potential risks arising from working in different settings and situations, and which are relevant to the placement the trainee is undertaking

b) will have taken steps to ensure that any potential risk are kept to a minimum, by putting in place sensible, reasonable, and responsible procedures, guidelines and precautions

Trainees also have the right to expect that if they have any doubts about their safety in a given situation that these doubts will be listened to and respected, and steps taken to address their concerns.

Trainees should not be expected to enter into a situation where there is a risk of significant harm; nor where sensible, reasonable, and responsible steps have not been taken to minimise risk. However, placement Trusts and Supervisors have the right to expect that trainees will conduct themselves in an appropriate and professional manner in potentially risky situations.

Although consciousness about safety needs to be built into the organisation, individual clinical psychologists, including trainees, need to take responsibility and appraise situations in terms of potential risk, and follow local health and safety procedures.

Some basic ways of reducing risk include:

- Seeing clients in designated clinical space where other members of staff are aware that the trainee is working with clients. Ideally clinical rooms should have a viewing window.
- Clients should not be seen in an isolated setting, or after normal clinic times when other staff are not available to respond to a problem.
- If one-to-one work is being conducted with a client who is recognised as presenting a risk, other staff need to be informed and available, with a clear plan in place should the alarm be raised.

Domicillary visits carry particular risks – these are discussed in detail below.

Finally, it can be easy to forget that trainees need to be mindful of safety issues when seeing research participants, especially when these are individuals about whom little is known.

Panic alarms

Many settings are equipped with panic alarms, either built in to clinical rooms, or carried by staff. Trainees should be carefully briefed on the use of these systems – they should know how to use them, and what response they can expect. They should also be briefed on how to respond if a panic alarm is set off by another member of staff.

Reporting Incidents

If a trainee is involved in an incident in the course of their duties they should report it immediately, or as soon as is feasible. If the incident has occurred on placement then both the supervisor (or other senior member of staff) needs to be informed, as well as the trainee’s Course Tutor. Trusts will have agreed reporting procedures, and these should be followed. If the incident has occurred in another setting the Course Tutor needs to be informed, as well as anyone else deemed appropriate.

If a trainee is involved in an incident they have the right to expect a sensitive response on reporting the incident, and longer term support if this is required.

Fire

Trainees are given a basic talk about responses to fire alarms and the need for basic fire awareness. However, it is important that trainees know explicitly what procedures to follow in the settings in which they work. This means knowing what the fire alarm sounds like, and procedures for evacuation (which include awareness of fire-exits, and procedures for evacuating clients).

Other health and safety policies

Most Trusts will have a range of specific policies designed to alert staff to the management of risks in their work environment. It is a good idea for these to be collated as part of a induction pack, and for trainees to be alerted to any policies which clearly apply to their practice.

Carrying Out Domiciliary Visits (DVs)

In some specialities seeing clients in their own home is an important part of the service, and as such should be part of the experiences of trainees. However, there can be risks when undertaking DVs, especially if the visits are conducted alone. It is important that trainees are aware of these, and that basic measures are taken to reduce risk and the likelihood of any difficulties. Equally it is important not to be alarmist. Nonetheless, trainees should not undertake a DV by themselves unless the patient is already known to them or to their supervisor, and any potential risks have been evaluated.

On receiving the referral

There should be clear information about the client's mental state and past history, and if in any doubt more information should be sought.

Initially joint visits are recommended, and can also be a good learning experience. If the referral arises in the context of team work this can give trainees an opportunity to gain experience of working with other team members.

If there is information indicating that there may be significant risks involved, either the trainee should not be given the case or the supervisor (or another team member) and trainee should make the initial assessment visit together.

Carrying out the visit

Where possible visits (and especially the initial visit) should be timed to allow the visit (and the return to base) to take place in daylight.

It is good practice to identify a specified individual who is on duty during the time of the visit. They should know when this is taking place, and (critically) when the trainee is expected back. It is also good practice to phone this person to confirm arrival, and to telephone again when leaving.

There should be an agreed procedure in place that alerts the ‘system’ if there is a significant delay in returning. This usually means a) the trainee contacts a specified person (to reassure the service that all is well), or b) the specified individual holds a contact number for the trainee which can be used to check that there is no cause for alarm. There should also be a clear procedure which can be followed in the event that, having followed these steps, the trainee is not contactable. For obvious reasons it is not good practice to schedule a visit is at the end of the day, when these steps will be hard to put in place.

The trainee should carry a mobile phone, and this phone should be left on so that the trainee is contactable.

If the service has a personal alarm this should be carried, and the trainee should know how to use it.

On arrival the trainee should be aware of exits, and seat themselves where they have unblocked access to an exit. If the trainee feels threatened or uneasy they should leave as soon as they can. Sometimes this will have been an error of judgment and will damage the chances of working with the client. However, being safe rather than sorry is a good motto.

It is essential for the trainee to record any particular difficulties or concerns about the visit, and to discuss these at supervision if there are doubts about continuing with DVs.

SECTION 8 APPENDIX 11: INVOLVEMENT OF CLINICAL PSYCHOLOGY TRAINEES AS CARE CO-ORDINATORS WITHIN THE CARE PROGRAMME APPROACH (CPA)

These notes are intended for trainees and for supervisors, and aim to clarify the roles trainees on the UCL Doctoral Course can undertake within the Care Programme Approach (CPA).

Background – clients to whom the CPA applies
The Care Programme Approach is designed to improve the co-ordination of care to all people under the care of mental health services.

CPA applies to every person aged 16 or over who is accepted for treatment or care by a specialist mental health service. Although the principles of CPA are appropriate in the care of mental health service users of all ages, the CPA does not explicitly relate to the care of children under the age of 16.

CPA applies to a wide range of services - Adult Mental Health, Mental Health Services for People with Learning Difficulties, Mental Health Care of Older People, Substance Misuse Services, and (for clients of 16-18 years) Child & Adolescent Services. As such, CPA applies to most patients seen by trainee clinical psychologists during their three years of Doctoral study.

CPA levels
There are two CPA levels - standard CPA and enhanced CPA.

Standard CPA: This level applies to individuals with “simple” mental health needs requiring support or intervention from a single professional or agency, who pose little danger to themselves and are not at significant risk if they lose contact with services. Most patients seen in outpatient settings fall under Standard CPA.

Enhanced CPA: This level is for individuals with complex needs, who require support and intervention from more than one professional or agency, and who would pose a significant risk to themselves or others if they lost contact with services. Patients who are classified as having a ‘severe and enduring mental health problem’ (SEMHP) usually fall under Enhanced CPA.

SEMHP includes people with *diagnoses* of psychotic illness, long standing depression, dementia, severe neurotic illness, personality disorder or developmental disorder; *disability* including problems with employment and recreation, personal care, domestic skills or interpersonal relationships; *duration* of any of the above for periods normally more than one year; and *risks to safety* including self-neglect, intentional self-harm, risk to safety of others or risk of abuse or exploitation by others.

Role of trainees as Care Co-ordinators under CPA
Care co-ordinators can come from any discipline. They are responsible for co-ordinating the care plan, maintaining contact with the service-user in the community, liaising with other services involved in the care plan, assessing carers’ needs where relevant, arranging review meetings and assessing risk in an ongoing way. They should also be familiar with the responsibilities of Section 117 aftercare as detailed in the Mental Health Act Code of Practice.

Role of trainees with clients on Standard CPA: Care co-ordinators can be any suitably experienced mental health worker. This includes trainee clinical psychologists who are regularly supervised by a qualified psychologist. Thus, in cases where the trainee psychologist is the only mental health professional seeing the patient, it is appropriate for the trainee to be the patient's care co-ordinator.

Role of trainees with clients on Enhanced CPA: Guidance makes it clear that unqualified staff cannot act as Care Co-ordinators for clients on enhanced CPA. Staff need to be both qualified and experienced to take on this role. Clearly trainee clinical psychologists should not be the named care co-ordinator for these clients.

By way of example, if a trainee is seeing a patient for psychological input in a CMHT, the named care co-ordinator would usually be either their own supervisor or another qualified member of the CMHT. The trainee's name should appear on the CPA form within the 'other people involved' section.

University College London Doctoral Course in Clinical Psychology

Your therapist is a trainee Clinical Psychologist (registered with University College London (UCL) and studying for a Doctorate in Clinical Psychology). Because they are in training their work is supervised by an experienced qualified clinician; it is also monitored by staff at UCL (all of whom are senior Clinical Psychologists).

As explained below, recording clinical sessions and writing and presenting clinical reports are part of training, but both of these activities need your consent. It is important.to be clear that they are completely independent – you do not have to consent to both areas if you do not want to.

This form explains what is involved.

1) Consent for recording clinical sessions

How are session recordings used?
The main reason for using recordings is to make sure that you are getting the best from your sessions – they improve the quality of the supervision your psychologist receives, because supervisors can hear for themselves how sessions are going. Recordings can also be used by staff at UCL to see whether your therapist is approaching their work in the most effective way.

Unless your psychologist explicitly indicates otherwise:

- recordings will only be listened to by your psychologist's supervisor or by staff at UCL who are overseeing their training
- recordings will only be used for educational purposes
- recordings will be deleted once their educational purpose has been completed

Some clients find it helpful to listen to a recording of their sessions, so this is another way in which they can be used. If you wish to have a copy of the recording this can be discussed with your psychologist.

Consent to record sessions

	Please initial
I understand that I am not obliged to give consent, and that if I do not want to this will not affect my treatment	
I understand that I can withdraw consent at any time	
I agree to the recording of my sessions	
I understand that the recording will be used for the purposes of supervision and education	
I understand that the recording will be deleted once its educational purpose has been completed	

If you are given a copy of the recording:

	Please initial
I accept that I am responsible for keeping my recording safe, and for destroying it when I have no further use for it, and that the Trust has no responsibility for it once it is given to me	
I understand that the recordings remain jointly the property of myself, my therapist and the service, and must not be published or shared without the written consent of all three parties	

Name and signature of trainee psychologist:

Name and signature of client:

Date:

2) Consent for writing and presenting clinical case reports

As part of their training your psychologist needs to submit some reports of their clinical work to UCL (to show the University that they are working effectively and appropriately). These are known as “case reports”.

From time to time trainees take part in case discussions at UCL, making a verbal report on their work with clients. These presentations are made to clinical staff at UCL and trainees undertaking the Doctorate in Clinical Psychology. The aim of case discussions is to help your psychologist work as effectively as possible.

Do written and verbal reports protect my privacy?
Case reports and verbal reports/discussions are set out in a way that maintains confidentiality (in other words, no-one will be able to identify you from the report or the discussion). For example, your name would be changed, and any information which could identify you, your family or anyone else involved in your case would be removed or changed.

Who sees case-reports?
The reports are reviewed by clinical staff at UCL (who are all senior Clinical Psychologists).

Who attends case discussions?
These are attended by clinical staff at UCL and by trainees undertaking the Doctorate in Clinical Psychology.

If you sign this consent form it indicates that you know that:

- your psychologist may (or may not) write a case report at some stage in your work together
- your psychologist may present some clinical material to professional colleagues, as part of their training
- the report is being written for educational purposes and will maintain confidentiality
- the report will only be looked at by your psychologist’s supervisor and by clinical staff at UCL
- that you can request to see a copy of the report (following the same procedure that applies should you want to see clinical reports written about you – your psychologist will explain the procedure)

Consent for case reports

	Please initial
I understand that I am not obliged to give consent, and that if I do not want to give consent this will not affect my treatment	
I understand that I can withdraw consent at any time	
I agree to the preparation of a case report based on my treatment	
I understand that the report is being written for the purposes of supervision and education	
I understand that the report will be seen only by my psychologist’s supervisor and by psychologists at University College London	
I understand that any case discussion would only be attended by staff and trainees at University College London	
I understand that I can request to see a copy of the report in the same way as I can request to see any clinical reports which relate to me	

Name and signature of trainee psychologist:

Name and signature of client:

Date:

EXTENUATING CIRCUMSTANCES REQUEST FORM

You will need to:

1. Read the Extenuating Circumstances regulations before completing this form.
2. Complete Parts 1, 2 & 3.
3. **Either** ask an appropriate authority to complete Part 4 **or** provide evidence on headed paper.
4. Submit your request as soon as possible and **no later than one week after the EC has taken place** to your **home Department/ Faculty Office** – please check your student handbook/ Moodle for details.
5. Keep a copy for your own records.

PART 1: STUDENT DETAILS

For completion by the student

Family Name:	
First Name:	
UCL ID Number:	

Contact Email:			
Programme:		**Year of Study:**	
Home Department:		**Home Faculty:**	

I agree that details of my Extenuating Circumstances Request can be shared with members of UCL staff who are directly responsible for making a decision.	☐

All personal data will be treated confidentially and will only be shared with UCL staff who are directly involved in considering your request and making a decision. If you are concerned about disclosing sensitive information to staff in your Department, you may ask for your request to be considered by the Faculty Extenuating Circumstances Panel. Please contact your Faculty Office for details of how to submit a confidential request.

What type of mitigation would you like to apply for?

The type of mitigation will be decided by the appropriate UCL authority and will take into consideration the need to be fair to all students and to maintain UCL's academic standards. The following will determine how your claim is processed but does not determine the outcome.

Extension of **up to one week**	☐
Extension of **more than one week** Please state length of extension being requested:	☐
Deferral (postponement) of assessment to the next occasion	☐
Condoned late submission	☐
Other – please specify with reference to the Extenuating Circumstances Regulations:	☐

Family Name:	
First Name:	
UCL ID Number:	

PART 2: AFFECTED ASSESSMENTS

For completion by the student

Please tell us about the assessments which have been affected by the EC:

Assessment 1:

Module name:			
Module code:			
Title of assessment:			
Assessment type (e.g. essay, exam):			
Assessment deadline/date:			
Assessment weighting (e.g. 40%):			
Mitigation sought for this assessment:			
Lecturer/ module organiser:			
Is this an interdepartmental module?	Yes/ No	Teaching department:	
Is this an intercollegiate module?	Yes/ No	College name:	

Assessment 2:

Module name:			
Module code:			
Title of assessment:			
Assessment type (e.g. essay, exam):			
Assessment deadline/date:			
Assessment weighting (e.g. 40%):			
Mitigation sought for this assessment:			
Lecturer/ module organiser:			
Is this an interdepartmental module?	Yes/ No	Teaching department:	
Is this an intercollegiate module?	Yes/ No	College name:	

If more assessments are affected, please continue on a separate sheet and attach this to your form.

Family Name:	
First Name:	
UCL ID Number:	

PART 3: DETAILS OF THE EC

For completion by the student

Dates affected by the EC:	**From:**	**To:**

Nature of the EC:

Please explain what has happened and how it has affected your assessment:

Signature of applicant: *An email from your registered UCL email address can also be accepted as a form of signature.*		**Date:**	

Family Name:	
First Name:	
UCL ID Number:	

PART 4: SUPPORTING EVIDENCE

For completion by a verifiable, independent authority

Students will need to ask a verifiable, independent authority (such as a GMC-registered medical practitioner, solicitor, undertaker, coroner, registrar of births, marriages and deaths, police officer, fire officer, court or tribunal officer) to either:

- Complete, sign and stamp this section of the form, or
- Provide evidence on headed paper

Full name:	
Role:	
Authority/ organisation:	

Please describe the nature and severity of the student's Extenuating Circumstances. Please be as clear, specific and unambiguous as possible so that we can provide appropriate mitigation for the student:

Please describe how the circumstance affects the student's ability to complete the assessments described in Part 2 (e.g. Will the student miss an exam? Will they be unable to meet a coursework deadline?):

Please provide the dates when the circumstance started and when the student was/will be fit to return to study. Please note that these will need to correlate with the dates of the assessments listed in Part 2:

Signature of person providing evidence:		**Date:**	
Official Stamp: *Where no official stamp is available, evidence must be supplied on headed paper*.			

Family Name:	
First Name:	
UCL ID Number:	

PART 5: DECISION

For Office Use Only

ONE WEEK EXTENSION

Does the request meet the definition of an EC as outlined in 'Annex 1: Acceptable Grounds for Extenuating Circumstances'?			
Is the claim supported by appropriate evidence?			
Extension approved?			
New deadline:			
Staff name:			
Role:			
Staff signature: *An email from your registered UCL email address can also be accepted as a form of signature.*		Date:	

DECISION OF THE FACULTY/ DEPARTMENTAL EC PANEL

Does the request meet the definition of an EC as outlined in 'Annex 1: Grounds for Extenuating Circumstances'?			
Is the claim supported by appropriate evidence?			
EC approved?	Accept	Reject	Pending - further evidence required
Approved mitigation:			
If applicable, has the student's teaching Department/ College been consulted on the mitigation?			
FECP/ DECP Chair's name:			
FECP/ DECP Chair's signature: *An email from your registered UCL email address can also be accepted as a form of signature.*		Date:	

Please ensure that ***Parts 1, 2 and 5 only*** *are communicated to the student, the teaching department/College and UCL Student Records (where applicable) within one week of the decision.*
Please send the ***full EC Form (Parts 1 to 5 inclusive)*** *to the secretary of the home Faculty or Departmental Extenuating Circumstances Panel for secure and confidential record-keeping.*

Marking Clinical Reports

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Marking procedure for all clinical reports

Each report is marked by a single marker, who does not know the candidate's identity. A sample of at least 10% of reports is reviewed by a moderating marker, to ensure fairness and consistency in the way that marks have been applied. The moderating marker is usually the lead marker for the set of clinical reports being marked.

The moderation sample contains:

1. All reports given a fail mark by the first marker
2. A selection of examples of "typical" passes and stipulated revisions
3. A selection of "borderline" marking examples (for example, stipulated revisions that were close to being awarded a pass, or vice versa).

In any rare instances where the moderating marker considers that there is a problem with the way marks have been applied, they will liaise with the Deputy Chair of the Board of Examiners who will give directions on appropriate action to be taken. Similarly, if the lead marker first-marks any reports and assigns them a "fail" mark, they will liaise with the Deputy Chair of the Board of Examiners to arrange moderation.

Moderating markers will not add additional comments to any mark sheets, and all candidates will receive marks and feedback from their first marker only. Moderators will log their process in a separate spreadsheet, and do not complete additional forms.

Marking categories

There are three possible marking categories:

- Pass
- Stipulated revisions (two months)
- Fail

Further details of the criteria for each marking category are set out in Section 25 of the course handbook.

Stipulated revisions will be required when there are issues or concerns that need to be addressed before the report can be of a passing standard. Often these will relate to the way the work is conceptualised or reported, and/or where an essential component of the report is missing or underdeveloped (as outlined in the marking guidance). Minor typographical and formatting issues are not a basis for stipulated revisions, and further guidance on this is available below.

The fail category is used when the report, as a whole, falls seriously short of expected professional or academic standards. Problems may include work that raises major ethical problems, a clearly inappropriate clinical approach to the work, or a confused or incoherent approach to reporting.

A failed report will first be reviewed by the moderating marker, and the fail will also go for moderation to the Chair or Deputy Chair of the Exam Board. If the fail would lead to failure of the course, then the Chair or Deputy Chair of the Exam Board may also consult with the Exam Board. All failed reports are sent once a year to an external examiner, who gives a general assessment about the marking standards to help the Department to calibrate the threshold for passing. In the case of a first failed report, a new report, usually based on a different piece of clinical work, will need to be submitted.

Resubmissions

Stipulated revisions (two months): Trainees submit the revised submission (resubmission) via Moodle. The resubmission **must** include:

- A written statement which provides a clear account of all the changes that have been made, cross-referring to the points on the mark sheet, ensuring that all points on the mark sheet are addressed. This should be included at the beginning of the revised submission, so the trainee is only uploading one document.
- The resubmission, showing changes from the original in 'track changes' (so that the examiner can see where changes from the original submission have been made).

As above, the written statement and resubmission should be uploaded as ONE document because Moodle cannot accept multiple uploads from the same candidate.

Resubmissions will be marked as soon as possible, and typically within a four-week timeframe.

The administrative team will alert the marker that a revision has been submitted and requires marking, and the marker will mark the resubmission. If it is judged to reach passing standard, no other marker will be involved. If there are still problems with the work, the moderating marker will also assess it.

Where revisions set out in the original marking have not been addressed or new major concerns are raised that mean the revised report is not of a pass standard, the resubmitted report will be given a fail.

There are two possible outcomes on a resubmission:

- Pass
- Fail

Marking guidance for Clinical Reports

When completing the mark sheet, markers should follow the marking guidance below.

Trainees and markers are advised to consult the Course Handbook, Section 21 for detailed guidance on the expectations for each of the clinical report formats. The guidance below applies generally across clinical reports, but markers should also be mindful that some optional report formats may vary in terms of their requirements. For example, Optional Report 7: “A Report of a Consultation with Experts by Experience/Carers” or 8: “A report of a piece of ‘leadership’ work”, would not require the inclusion of an individualised client formulation and other contents would be applicable. For this reason, the handbook should always be consulted alongside this more general marking guidance document.

All reports should demonstrate ethical and competent clinical work, informed by appropriate psychological theory, along with a capacity to reflect at an appropriate level on process issues, on relevant cultural and contextual factors, and on clinical, professional or organisational issues that arose.

At a minimum, each report would be expected to contain the following elements. Markers should ensure that reports are appropriate in terms of content and structure, but should not necessarily insist that particular elements are contained within particular sections of the report, as long as overall readability and conceptual clarity are maintained.

1. Introduction

All reports should orient the reader by introducing the clinical and conceptual issues with which the report is concerned.

2. Cultural and contextual considerations

Whether in the introduction or elsewhere, all reports should include an appropriately reflective and developed description of relevant contextual and cultural factors. This does not necessarily need to include the clinician’s own identity or cultural background, especially given that trainees may be conscious of disclosing personally identifying information within an anonymised marking structure.

In reports describing assessment or intervention work with a client, at a minimum the client’s cultural background should be situated and linked with reflections on implications for formulation and/or intervention. These reflections may come later in the report. In reports describing consultation, leadership or systems-level work, relevant cultural and contextual considerations should be identified and linked with the approach taken.

3. Formulation

As above, report formats vary in their requirements and both markers and trainees should consult the course handbook for detailed guidance regarding the specific expectation for the type of clinical report under consideration.

However as a general principle, all clinical reports should contain a formulation, meaning that a conceptualisation of the piece of work is presented, linked with relevant psychological theory. Trainees will often need to go beyond course teaching and undertake independent reading to develop this thinking.

Formulations should be written in full text; while a diagrammatic formulation may also be included, this should not replace a written formulation.

Reports of client-facing work such as an assessment or intervention should include a written formulation, linked with relevant psychological theory, demonstrating how the presenting problem/s have been conceptualised. Reports of consultation, leadership or other systems-level work may not include a traditional formulation, but should include at some stage a written explanation of how the piece of work has been conceptualised, drawing on relevant psychological theory.

4. Reflections

All clinical reports should be reflective in tone throughout. The reflections section **must reflect on points of learning** and how the trainee would do things differently. These may refer to the following, but this list is not prescriptive or exhaustive:

- Reflections on outcomes
- Cultural and contextual factors
- Alternative ways the presenting issue could be conceptualised or treated
- How supervision supported learning or guided the piece of work
- Reflection on relationships (including therapeutic process issues)
- Broader implications for the model or evidence base

It is not required or expected that a particular reflective model or approach is used to structure this section; however, there should be evidence (whether in a specific paragraph or throughout the report) that the trainee has reflected to an appropriate level on specific points.

In the reflections section, it may be appropriate to bring in other models or theories, besides the main theoretical orientation that has been used to conceptualise and guide the piece of work. However, the choice to draw on another model should be explained and cited. For example, a report on a CBT intervention could conclude with reflections on transference and countertransference, accompanied by a citation to literature that applies these frameworks to CBT intervention within a cognitive-behavioural framework. In this example, if psychodynamic literature had been cited and there was therefore an apparent lack of conceptual coherence to the report, this would become a point of feedback.

Typographical, referencing and formatting issues

A good standard of writing is expected, and it is not the job of the marker to act as copy-editors, although it is good practice to draw issues to the trainee’s attention.

Minor typographical, formatting and referencing issues should not usually form the basis of stipulated revisions, and should not in themselves be a barrier to a report being passed. Examples of minor issues would be relatively isolated (i.e., non-systematic) occurrences, which do not substantially affect the comprehensibility or quality of the report.

Where minor issues are identified, these should be highlighted in the "recommendations and future learning" section of the mark sheet.

Stipulated revisions **should** be given in relation to sustained or major writing or formatting issues. Examples of major issues would be a failure to use the correct APA formatting style throughout a report; sustained inappropriate use of language (e.g., language that is not sufficiently respectful or person-centred); or sustained and frequent misspellings or grammatical errors that affect comprehensibility. One-off or infrequent examples of the above should be added instead to the recommendations section as above.

In cases where the general writing style is below the expected academic standard, or the level of errors is high, this should be clearly indicated on the mark sheet. This can be done by using the checkbox on the mark sheet provided, indicating that the trainee should discuss support around academic writing with their course tutor.

Guidance on marking resubmissions

As above, resubmissions can only be given a "pass" or "fail" grade. In cases where stipulated revisions have not been satisfactorily addressed, including cases where sustained typographical, formatting or referencing errors that had been stipulated have not been remedied, the report will usually be given a "fail" and passed to the moderating marker for review.

Following passing a resubmission, any remaining feedback should be advisory and entered into the "Recommendations and future learning" box on the marker sheet.

Providing feedback

Style of feedback

Markers should hold in mind that trainees are likely to have a great personal investment in the piece of clinical work they are reporting, and the tone of the feedback can therefore affect how it is received and used. Feedback should be fair, accurate, constructively critical and contribute to learning; and it should also be delivered in an encouraging and supportive tone.

While undertaking a busy, anonymous marking load it could be possible to overlook how early in their careers trainees are (particularly for the compulsory reports 1 and 2), and how personal the feedback can feel. We therefore recommend markers take the tone of a supervisor, giving supportive supervision to a trainee.

Structure of feedback

Mark sheets should be between 1 to 1.5 pages in length. They should be structured in the following way:

i) General comments

The marker may wish to begin with a brief, concise summary of their overall response to the report, highlighting any themes relating to strengths and constructive feedback.

ii) Strengths

Markers should ensure that prior to delivering structured feedback, they highlight genuine strengths of the report. Even a report given a fail grade will have demonstrated some strengths that the trainee can build on for their next attempt.

iii) Stipulated revisions (if applicable)

This should contain **bullet-pointed** items linked to relevant page numbers. Points should be **clear, concise and concrete**, and it should be clear what the trainee needs to do to meet the marker's requirements.

iv) Reasons for fail grade (if applicable)

This should contain **bullet-pointed** reasons for the report being given a fail grade. These should be linked to, or followed by, a **clear, concise and concrete** set of recommendations for how the trainee could seek to address the limitations in a future report. As above, the tone should be constructive, supportive and encouraging.

v) Recommendations and future learning.

Markers should use this section to provide the trainee with the benefit of their clinical and academic expertise, rather than incorporating such comments into the text around the stipulated revisions. This section will also be helpful for trainees given straight pass or fail grades. As above, this should be delivered in the tone of a supportive, encouraging supervisor.

Markers should use this section for ideas that would have improved the report in their view, but which are not sufficiently "objective" for them to be stipulated as requirements, or which are recommendations for clinical practice. Markers should also use this section for more "minor" considerations for trainees to take forward for future reports. Examples of such feedback would include:

- Using a particular reflective model to structure the reflections section

- Using a particular, favoured theory to add to the formulation
- Re-thinking the clinical approach taken, or adding to the intervention

As a general rule, markers should include a piece of feedback as a recommendation rather than a stipulated revision when it is likely that another marker with a different clinical background or orientation would not have raised the same issue (for example, recommending a specific model or theory is applied).

Feeding back on concerns about the clinical approach taken

Markers should be mindful that at the point of marking, the piece of work reported is likely to have been completed, and to have been in line with clinical practice in the placement context. Where concerns about the clinical approach are raised, trainees are therefore understandably likely to counter that it is too late, had been agreed by their supervisor and/or that this is the treatment model used in their placement.

For this reason, it is helpful firstly to distinguish between major and minor concerns about the clinical approach taken. Where there are substantial concerns about the suitability, professionalism or ethics of the approach taken, markers should consult the handbook marking guidance and consider whether the report should therefore be failed. Where concerns are more minor and the report will pass or receive stipulated revisions, markers should either:

- Clearly stipulate that the required revision relates to asking for **further reflection** on the possible limitations of their approach (and why); OR
- Include feedback and suggestions for further thought in the “recommendations and further learning” section rather than the stipulated revision section.

Appendix 1: Marker Sheet – Pass

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

■ Pass

☐ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Recommendations and future learning:

Appendix 2: Marker Sheet – Stipulated Revisions

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

☐ Pass

■ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Stipulated revisions:

Recommendations and future learning:

Appendix 3: Marker Sheet - Fail

Final Marker Sheet

Marker 1 name

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT ? – 20?? INTAKE

Trainee ID Number:

☐ Pass

☐ Stipulated revisions (2 months)

■ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

Strengths:

Reasons for fail grade:

Recommendations and future learning:

Appendix 4: Example completed marker sheet

Final Marker Sheet

Example Marker 1

UNIVERSITY COLLEGE LONDON, DOCTORATE IN CLINICAL PSYCHOLOGY

CLINICAL REPORT 1 – 2023 INTAKE

Trainee ID Number: XXXXXX

☐ Pass

■ Stipulated revisions (2 months)

☐ Fail

☐ The quality of writing in this report falls below an acceptable standard. The trainee must contact their Course Tutor in order to develop a remedial action plan.

(where relevant this box should be ticked in addition to one of the marking categories)

COMMENTS

General comments:

This was a well-written first clinical report, describing a complex piece of engagement work and a thorough assessment of a client's presenting difficulties relating to OCD and perfectionism. The reporting was clear, but could benefit from a more concise description of the history of Ms A's treatment and compulsive behaviours, with a more developed formulation linked to psychological theory. There is also a need to clarify an aspect of risk assessment.

Strengths

This was an engaging report, which described what sounds like a sensitive and careful assessment. Ms A's personal history, cultural context and values were clearly described, accompanied by reflections on cultural humility and the role of supervision in building engagement. The final reflections on the limitations in the service context regarding length of assessment were appropriate and well-developed. The writing style throughout was clear and reflective in tone, and there was a clear demonstration of a compassionate, open stance towards Ms A's feedback on the assessment process. Overall, this sounds like a successful assessment and a strong piece of clinical work – well done.

Stipulated revisions:

- The list of past treatments Ms A received over the past 25 years is very detailed and potentially identifying (p1). Please condense this into 2 or 3 summary sentences instead.
- The list of compulsive behaviours and their change over time is extensive (p2). It would be helpful to make this section more concise by reporting the key presenting behaviours you identified together, and clarifying that this has changed over time with one or two examples.
- Alongside the above, the formulation paragraph is relatively brief (p4). You need to explain the model of OCD you are drawing on, linked with relevant psychological theory and citations. Previously you had noted some thoughts relating to personal responsibility (p3). You need to ensure you include in your formulation how you are linking thoughts, behaviours and emotions, and your conception of the maintenance cycle.
- In your helpful section on identifying strengths and protective factors, you mention that Ms A's relationship with her partner had improved following high expressed emotion and anger/conflict in the past (p4). You need to clarify how you assessed historical/current risk in relation to this disclosure.

Recommendations and future learning:

I was struck by the positive relationship that you developed with Ms A, such that she was able to attend in-person sessions with you despite having worries about leaving her home. It sounds like the careful engagement work by telephone and letter was helpful towards facilitating this. I also wondered if you might reflect a little more in future on the power dynamics within clinical work, and whether in retrospect Ms A might have been working hard to be a "good client" (rather like being a "good mother", "good daughter" p.3).

I noted that you described Ms A's distress about breaking her routines (p2) and around strong smells (p2). There seemed to be a strong sensory component to some of the compulsions. You also described her struggling to make friends and fit in, at school and work (p1). I wonder if you or Ms A considered whether autistic traits could be playing any role in this, and if it could have been helpful to consider a brief autism screening tool?

Overall, this was a good report of a thoughtful, careful assessment, well done. I look forward to reading your revised report in due course.

Camden and Islington NHS
NHS Foundation Trust

BULLYING AND DISCRIMINATION POLICY AND PROCEDURE

AUGUST 2019

This policy supersedes all previous policies for Bullying and Discrimination Policy and Procedure

Policy title	Bullying and Discrimination Policy and Procedure		
Policy reference	HR03		
Policy category	Human Resources		
Relevant to	All staff		
Date published	September 2019		
Implementation date	September 2019		
Date last reviewed	August 2019		
Next review date	August 2022		
Policy lead	Malwina Paulus, HR Business Partner and Head of ER		
Contact details	Email: Malwina.Paulus@Candi.nhs.uk	Telephone: 0203 317 7183	
Accountable director	Director of HR and OD		
Approved by (Group):	Joint Policy Sub Group August 2019		
Approved by (Committee):	Workforce Committee August 2019		
Document history	Date	Version	Summary of amendments
	June 2000	1	New Policy
	August 2007	2	Policy review
	March 2009	3	Policy review
	September 2009	4	Policy review
	May 2013	5	Policy review
	April 2016	6	Policy review – added reference to HR Investigation policy and procedure
	Aug 2019	7	Policy review
Membership of the policy development/ review team	HR; Staffside Representatives; Trust Managers/Directors and Nursing Leads		
Consultation	Joint Policy Sub Group Workforce Committee		

DO NOT AMEND THIS DOCUMENT

Further copies of this document can be found on the Foundation Trust intranet.

Contents

1. INTRODUCTION

1.1 Camden and Islington NHS Foundation Trust recognises that discrimination and bullying can create a threatening and intimidating work environment, which can adversely affect health and wellbeing and performance of employees. The Trust believes that employees have a right to work in an environment free from bullying or harassment.

1.2 Camden and Islington NHS Foundation Trust believes that it is a mutual benefit to the Trust and its employees to work in partnership with Staff side. This policy has been developed and agreed by management and Staff side, in order to ensure that staff are treated consistently and fairly.

2. SCOPE OF THE POLICY

2.1 This policy and procedure applies to all employees of the Trust including doctors in training and Trust doctors. Agency workers, bank staff and third party staff working under contract are also required to adhere to the principles identified within this policy and may use this policy to raise concerns about the behaviour of substantive Trust employee(s).

2.2 The policy does not form part of any employee's contract of employment and it may be amended at any time. The Trust may also vary any parts of this policy, including any time limits, as appropriate in any case.

2.3 The Trust also expects staff members to uphold the Trust Values while carrying out their responsibilities to ensure compliance with the policy.

3. AIMS AND OBJECTIVES

3.1. The aims of the policy are to set out the framework to provide proper redress for individuals facing discrimination and bullying and to assist in identifying and dealing with these issues, in line with the Trust’s Equality, Diversity and Inclusion Policy. This procedure is designed to support all Trust staff who feels they have suffered from bullying or discrimination (including harassment and victimisation) from another Trust employee(s). It is not intended for use in relation to complaints from members of the public concerning service delivery and related matters. Neither does it apply to discrimination or bullying of employees by patients/service users.

3.2 This policy encourages consideration of informal resolution in the first instance. Individuals or groups of staff who consider themselves to be subject to bullying or harassment should first take steps to try and resolve it themselves. People may not be aware that their behaviour or some aspects of their behaviour is perceived as bullying or harassment. Individuals or groups may need support in doing this and there are many ways this support can be provided.

4. DUTIES AND RESPONSIBILITIES

4.1. Managers

- Managers have a particular responsibility for ensuring a culture of respect and dignity through role modelling positive behaviours and promoting health and wellbeing of people who work at the Trust;
- To maintain a working environment free from bullying and discrimination
- To ensure employees are aware of the Bullying and Discrimination Policy and Anti-Bullying and Harassment Initiative;
- Take prompt action to stop bullying and discrimination as soon as it is identified;
- To promote informal resolution in the first instance when issues occur;
- Where necessary, to conduct formal investigations in a timely manner;
- To maintain confidentiality at all times without exception;
- To seek guidance from the Employee Relations Team when necessary.

4.2. Staff Members

- To treat colleagues, visitors and patients with respect and dignity;
- To take personal responsibility to ensure a working environment free from bullying and discrimination;
- To familiarise themselves with the Bullying and Discrimination Policy and Anti-Bullying and Harassment Initiative;
- To ensure that patients, visitors and the people we employ are treated equally and not discriminated against;
- To be prepared to receive constructive feedback and change behaviour where perceived by others in a negative way and to ask for help/support if this is required.
- To feedback to colleagues in a timely and professional manner where behaviour is considered unacceptable.

4.3. The Employee Relations service

- Provide guidance and support to all employees and management with regard to the implementation and execution of this policy.
- Encourage and support resolution without requiring a formal investigation.
- Support investigating managers to ensure that any formal investigations are conducted within an agreed time.

4.4 Trade Unions

- To support union members in reaching informal resolutions or during a formal investigation, where necessary;
- To work in partnership with managers to tackle bullying and harassment at work.

5. DEFINITIONS

5.1**. "Discrimination"** is defined as an act which has the effect of treating a person less favourably than another on the grounds of sex, race, religion, religious or philosophical belief, disability, sexual orientation, gender reassignment, age, or part-time or fixed-term working status. In addition discrimination can occur by association. Discrimination can also include harassment and/or victimisation, which are defined as follows:

5.2. **"Harassment"** is defined as any conduct based on sex, race, religion, religious or philosophical belief, disability, sexual orientation, age, or part-time or fixed-term working status which is unreciprocated or unwanted or affects an individual’s dignity at work or creates an intimidating, hostile, degrading, humiliating or offensive environment for an individual. **(see examples of behaviour – appendix 1)**

5.3. **“Bullying”** at work is behaviour that is threatening, aggressive or intimidating; or abusive, insulting or offensive; or cruel or vindictive; or humiliating, degrading or demeaning. Bullying will inevitably erode the victim's confidence and self-esteem. It normally relates to negative behaviours that are repeated and persistent, and deliberately targeted at a particular individual. Bullying is often an abuse of power, position or knowledge, and may be perpetrated by the victim's manager, his or her peers or even by subordinates. The reasonable, legitimate and appropriate exercise of management responsibility does not constitute bullying. **(see examples of behaviour – appendix 1)**

5.4. **"Victimisation"** is defined as
Victimisation broadly refers to bad treatment directed towards someone who has made or is believed to have made or supported a complaint under the Equality Act.

It includes situations where a complaint hasn't yet been made but someone is victimised because it's suspected they might make one.

If an individual gives false evidence or makes an allegation in bad faith, then they are not protected from victimisation under the Act. (The Equality Act 2010)

5.5. Bullying or harassment may take place face to face, in writing or by phone. It may be targeted at an individual or a group of people.

6. ADVICE, SUPPORT AND UNION REPRESENTATION

6.1. The Trust provides a range of support that an employee can access if they feel they are subject to bullying, harassment, or discrimination:

6.1.1. Occupational Health - staff can self-refer or be referred by their manager. The Trust's Occupational Health Service can be contacted PAM OHS on 0203 8666600.

6.1.2. Anti-Bullying & Harassment Ambassadors via email NoBullying@candi.nhs.uk or by telephoning to 020 3317 6307. This is a private & confidential service;

6.1.3. Freedom to Speak Up Guardian by telephoning to 078 2450 9792 or email raising.concerns@candi.nhs.uk The purpose of the Freedom to Speak Up role is to support whistle blowers, or those who wish to raise concerns, by being available as an independent and impartial person for staff who wish to discuss issues informally

6.1.4. Employee Assistance Program – Confidential Support, Counseling and Guidance helpline available 24/7, 365 days a year. EAP can be accessed by phoning 0800 882 4102;

6.1.5. Mediation services – staff can access the services by contacting one of the members of the Employee Relations Team https://intranet.candi.nhs.uk/contact-employee-relations-team

7. PROCEDURE FOR MAKING A COMPLAINT OF BULLYING OR DISCRIMINATION

7.1. KEEPING A RECORD

7.1.1. It is recommended that cases are dealt with as soon as possible after an incident takes place. The longer an issue is left unreported, the more difficult it may be to resolve it.

7.1.2. It's important to identify the behaviours that are being experienced as unpleasant or bullying. It's helpful to make sure that the specific incidents are clearly defined in terms of the time, content and frequency of behaviours.

7.2. STAGE 1: Informal Resolution

7.2.1. Every effort should be made to resolve the issue informally in the first instance, if this is appropriate and safe to do so; This response is most appropriate when the working relationship is still reasonably positive and when the unwanted behaviour is recent. A mutual willingness to discuss the issues and to work for a win–win solution is a good indicator of success and can preserve good working relationship;

7.2.2. As soon as possible after an employee considers that an incident of bullying/discrimination has occurred, the employee should make it clear to the offender(s) that s/he does not like the behaviour and if possible ask the offender(s) to stop behaving in this way.

7.2.3. The employee who feels bullied/discriminated against should discuss the issue with their manager and, if they feel unable to take action personally, they can ask for assistance from their line manager to facilitate a conversation. If the complainant's line manager is the person alleged to have carried out the bullying or discrimination, the matter should be reported to the next-in-line manager above her/him. Alternatively, advice can be sought from the Employee Relations Team. This approach is most appropriate when there are strong emotions and there is a need for support in resolving the problem. The aim of these meetings is to re-establish effective working relationships. The focus is on how both parties communicate with each other, manage differences of opinion and conflict, and keep each other informed of respective areas of work that impact on each other.

7.2.4. If staff would like to access the mediation service, they can fund further information on the Trust’s intranet: https://intranet.candi.nhs.uk/mediation-service-staff

7.3. STAGE 2: Making a Formal Complaint

7.3.1. In circumstances where the informal resolution was not successful or is not appropriate, staff can raise a formal complaint. They should report such incidents in writing to their line manager (or if the complaint is being made against their line manager, their manager’s manager), providing them with details of the incidents, dates, possible witnesses, etc. Alternatively, the complainant can raise the issue via the Employee Relations Team;

7.3.2. Once a formal complaint is made, the matter should be escalated to a more senior manager to the line manager of the alleged perpetrator who may commission a formal investigation and appoint an investigating manager in line with the Trust’s HR Investigation Policy and Procedure;

7.3.3. Investigations are required when:

7.3.3.1. there have been allegations of very serious behaviours, or

7.3.3.2. the options of speaking directly to the person or addressing the concern through facilitated or mediated conversations have proved to be unsuccessful.

7.3.4. An investigation to establish the facts of a case will be carried out by an investigating manager before a decision is made on whether formal disciplinary action is required;

7.3.5. If, as part of the investigation, it is found that the allegations of bullying/harassment/victimisation/discrimination are substantiated, the matter will proceed to a disciplinary hearing under the Trust's Disciplinary Policy. In these circumstances there investigation report produced as part of this policy will be used in the disciplinary proceedings.

8. APPEALS

If the complainant disagrees with the outcome of the investigation, they have the right to raise an appeal within 10 working days from the receipt of the outcome letter. The appeal will be dealt with under stage 3 of the Trust's Grievance Policy. This will be the last stage of the policy.

9. POLICE INVOLVEMENT

In cases of alleged assault or alleged behaviour that is considered to be a criminal offence, the Trust will contact the Police for their appropriate action if the complainant so wishes and/or if the incident is considered to be a serious criminal matter.

10. PRIVACY/CONFIDENTIALITY

At all times both parties' right to privacy will be respected and no information about the complainant will be imparted unless absolutely necessary, and will always be discussed with the parties involved prior to the release of information. It is recognised that confidentiality is essential, and those investigating complaints will make arrangements to ensure secure storage of papers etc. The complainant and the person against whom the complaint is made will have the right to see all the relevant evidence gathered, including notes of meetings, regardless of the outcome.

11. TRAINING

There are no specific training requirements in order to implement this policy. However, managers will be able to access advice from the HR Department on the implementation and interpretation of this policy.

12. DISSEMINATION AND IMPLEMENTATION ARRANGEMENTS

This policy will be available to employees on the Trusts intranet. Copies can also be obtained by contacting the Employee Relations team. The Employee Relations team will advise on the interpretation and implementation of this policy. Reviews of this policy will be subject to consultation and agreement with Staff Side partners through the Trust's Joint Policy Sub Group.

10. ASSOCIATED DOCUMENTS

- Grievance Policy
- Disciplinary Policy
- HR Investigations Policy and Procedure

11. MONITORING

Elements to be monitored	**Lead**	**Method for monitoring compliance**	**Frequency**	**Reporting (Committee/Group responsible for overseeing implementation of actions)**	**Parent Committee(Board sub-committee that receives assurance)**
The application of this procedure to resolve complaints of bullying and discrimination will be monitored against the protected characteristics defined by the Equality Act 2010.	HR	Audit	Quarterly	Workforce Committee Equality and Diversity Committee	Required changes to practice will be identified and actioned within a specific timeframe. Lessons learnt will be shared with appropriate stakeholders.

13. APPENDICES

Appendix 1 Examples of Bullying and Harassment

The following is not intended to be exhaustive but to provide some examples of bullying and harassment behaviour, which the trust deems to be unacceptable:

Bullying examples:

- shouting at a colleague;
- persistently negative and inaccurate attacks on a colleague's personal or professional performance;
- criticising a colleague in front of others;
- spreading malicious rumours/making malicious allegations;
- threatening behaviour, both verbal and physical;
- persistently setting objectives with impossible deadlines or unachievable tasks;
- removing and replacing areas of responsibility with menial or trivial tasks
- taking credit for work achieved;
- undervaluing a colleague's contribution, placing unreasonable demands on and/or over-monitoring a colleague's performance;
- withholding information with the intent of deliberately affecting a colleague's performance;
- excluding colleagues by talking solely to third parties to isolate another;
- isolating staff by treating them as non-existent and preventing them accessing opportunities.
- behaving or speaking in a way which makes someone feel bullied because of their actual or perceived sexuality. People may be a target of this type of homophobic bullying because of their appearance, behaviour, and other physical traits or because they have friends or family who are gay, lesbian, bisexual, or transgender or just because they are seen as being different. Biphobia is a source of discrimination against bisexuals, and may be based on negative bisexual stereotypes or irrational fear.

Harassment examples:

- unwanted non-accidental physical contact ranging from unnecessary touching, patting, pinching or brushing against a colleague's body, to assault or coercing sexual relations;
- unwelcome sexual advances, propositions or pressure for sexual activity; offensive flirting;
- continued suggestions for social activity within or outside the workplace, after it has been made clear that such suggestions are unwelcome;
- suggestions that sexual favours may further a colleague's career or refusal may hinder it e.g. promotions, salary increases etc.;
- the display of pornographic or sexually aggressive pictures, objects or written materials;

- leering, whistling or making sexually suggestive comments or gestures, innuendoes or lewd comments;
- conduct that denigrates, ridicules, intimidates an employee because of his or her protected characteristics as per the Equality Act 2010 as defined in appendix 3 as derogatory or degrading remarks, graffiti, which are gender or race related and offensive comments about appearance or dress;
- conduct that denigrates or ridicules a colleague because of his or her race, such as derogatory remarks, graffiti, jokes. Such conduct can be verbal or physical;
- the display or sending of offensive letters or publications with language linked to race and threatening behaviour;
- being “frozen out” of conversations, jostling or assault.

Is it firm but fair management or bullying & harassment?

The differences between a manager who is firm but fair and a manager who is bullying or harassing staff are often ambiguous. The Department of Work & Pensions equality team have developed a framework to make clear distinctions between two management styles.

Firm but fair manager	**Bullying or harassment**
Consistent and fair	Aggressive, inconsistent and unfair
Determined to achieve the best results, but reasonable and flexible	Unreasonable and inflexible
Knows their own mind and is clear about their own ideas, but willing to consult with colleagues and staff before drawing up proposals	Believes that they are always right, has fixed opinions, believes they know best and not prepared to value other people’s opinions
Insists on high standards or service in quality of behaviour in the team	Insists upon high standards of service and behaviour but blames others if things go wrong
Will discuss in private any perceived deterioration before forming views or taking action and does not apportion blame on others when things go wrong	Loses temper, regularly degrades people in front of others, threatens official warnings without listening to any explanation
Asks for people’s views, listens and assimilates feedback	Tells people what is happening, does not listen

Source NHS Employers Guidance – Bullying & harassment April 2006

Appendix 3

C&I Equality Impact Analysis Guidance Document

1. Please indicate the expected impact of your proposal on people with protected characteristics

Characteristics	Significant +ve	Some +ve	Neutral	Some -ve	Significant -ve
Age			X		
Disability			X		
Ethnicity				X	
Gender re-assignment:				X	
Religion/Belief:				X	
Sex (male or female)			X		
Sexual Orientation				X	
Marriage and civil partnership			X		
Pregnancy and maternity			X		
The Trust is also concerned about key disadvantaged groups event though they are not protected by law					
Substance mis-users			X		
Homeless people			X		
Unemployed people			X		
Part-time staff			X		

Please remember just because a policy or initiative applies to all, does not mean it will have an equal impact on all.

2. Consideration of available data, research and information

Please list any monitoring, demographic or service data or other information you have used to help you analyse whether you are delivering a fair and equitable service. Social factors are significant determinants of health or employment outcomes. Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equitable service. Social factors are significant determinants of health outcomes. Please consult these types of potential sources as appropriate. There are links on the Trust website:

- Joint strategic needs analysis (JSNA) for each borough
- Demographic data and other statistics, including census findings
- Recent research findings (local and national)
- Results from consultation or engagement you have undertaken
- Service user monitoring data (including age, disability, ethnicity, gender, religion/belief, sexual orientation and)
- Information from relevant groups or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or complaints or compliments about them

Recommendations of external inspections or audit reports

	Key questions (supports EDS Goals)	Your Response *Please reference data, research and information that you have reviewed which you have used to form your response*
2.1	What evidence, data or information have you considered to determine how this policy/ development contributes to delivering better health outcomes for all?	Employment case law, Equality Act 2010, ACAS code of conduct
2.2	What evidence, data or information have you considered to determine how this policy/ development contributes to improving patient access and experience?	N/A

2.3	What evidence, data or information have you considered to determine how this development/policy contributes to delivering a representative and well supported workforce?	Michael West publications about motivated and engaged workforce
2.4	What evidence, data or information have you considered to determine how this policy/development contributes to inclusive leadership and governance?	N/A

3. It is Trust policy that you explain your proposed development or change to people who might be affected by it, or their representatives. Please outline how you plan to do this.

Group	Methods of engagement
Staff	B&D advisors, promotion of the policy through leadership in the deivisions

4. Equality Impact Analysis Improvement Plan

If your analysis indicates some negative impacts, please list actions that you plan to take as a result of this analysis to reduce those impacts, or rebalance opportunities. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Negative impacts identified	**Actions planned**	By who
Ethnicity, Gender re-assignment, religion, sexual orientation	Managers will be made aware of the policy and the imporationce of encouraging employees to speak up	ER and HRBPs

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by Service Director, Clinical Director or an Executive Director or their nominated deputy. If this Equality Impact Analysis relates to a policy, procedure or protocol, please attach it to the policy and process it through the normal approval process. Following this sign off by the Sub Policy Group your policy and the associated EqIA will be published by the Trust's Policy Lead on the website.

If your EqIA related to a service development or business /financial plan or strategy, once your Director or the relevant committee has approved it please send a copy to the Equality and Diversity Lead (equalityanddivesity@candi.nhs.uk), who will publish it on the Trust's website. Keep a copy for your own records.

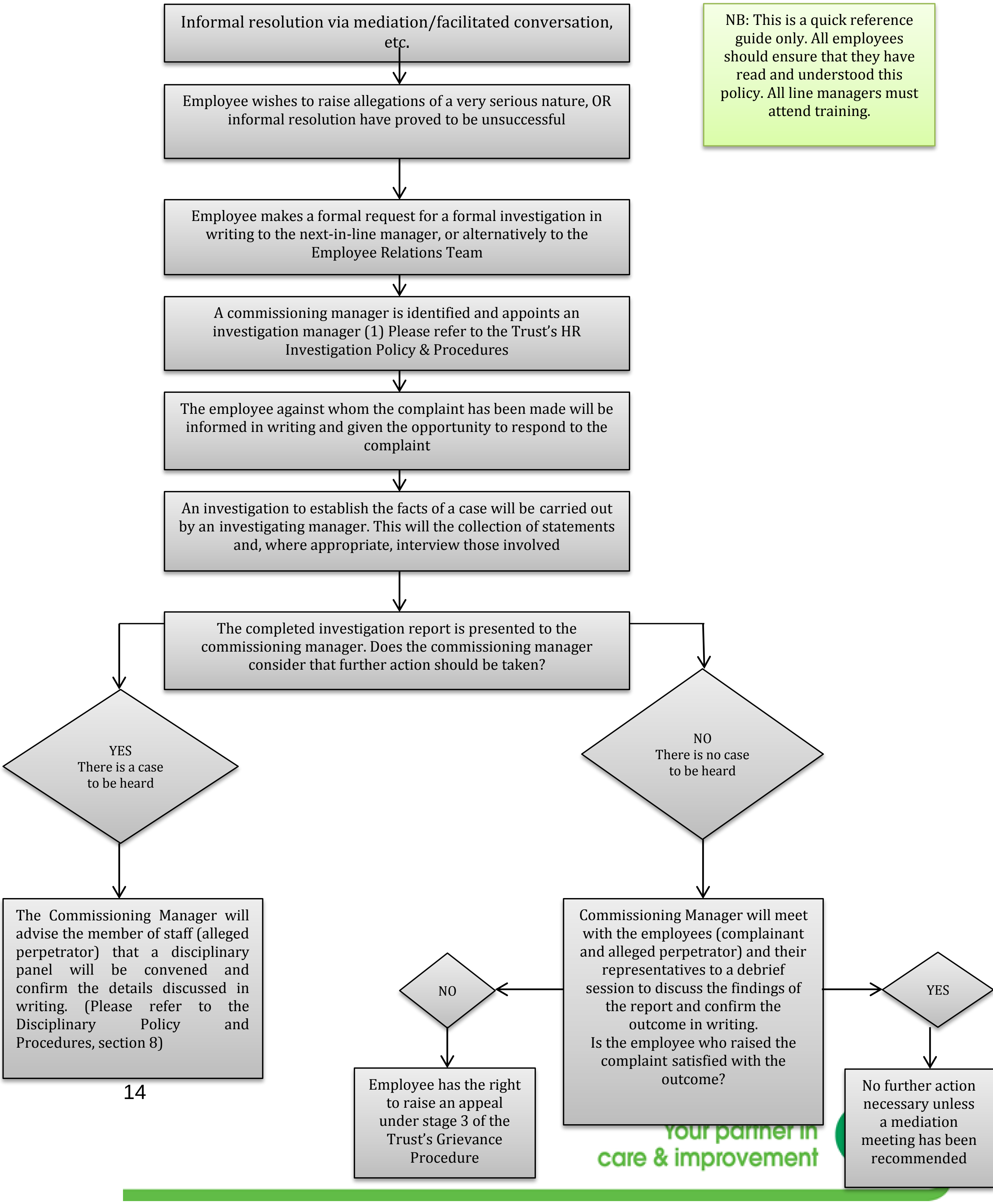
I have conducted this Equality Impact Analysis in line with Trust guidance

Your name:	Position
Signed:	Date:

Approved by:

Your name:	Position
Sign:	
Date	

Requesting a formal investigation



NB: This is a quick reference guide only. All employees should ensure that they have read and understood this policy. All line managers must attend training.

Informal resolution via mediation/facilitated conversation, etc.

Employee wishes to raise allegations of a very serious nature, OR informal resolution have proved to be unsuccessful

Employee makes a formal request for a formal investigation in writing to the next-in-line manager, or alternatively to the Employee Relations Team

A commissioning manager is identified and appoints an investigation manager (1) Please refer to the Trust's HR Investigation Policy & Procedures

The employee against whom the complaint has been made will be informed in writing and given the opportunity to respond to the complaint

An investigation to establish the facts of a case will be carried out by an investigating manager. This will the collection of statements and, where appropriate, interview those involved

The completed investigation report is presented to the commissioning manager. Does the commissioning manager consider that further action should be taken?

YES
There is a case
to be heard

The Commissioning Manager will advise the member of staff (alleged perpetrator) that a disciplinary panel will be convened and confirm the details discussed in writing. (Please refer to the Disciplinary Policy and Procedures, section 8)

NO
There is no case
to be heard

Commissioning Manager will meet with the employees (complainant and alleged perpetrator) and their representatives to a debrief session to discuss the findings of the report and confirm the outcome in writing.
Is the employee who raised the complaint satisfied with the outcome?

NO

Employee has the right to raise an appeal under stage 3 of the Trust's Grievance Procedure

YES

No further action necessary unless a mediation meeting has been recommended

Camden and Islington NHS
NHS Foundation Trust

GRIEVANCE POLICY & ROCEDURES

MARCH 2019

This policy supersedes all previous policies for Grievance

Your partner in care & improvement

Policy title	Grievance Procedure		
Policy reference	HR08		
Policy category	HR Operations		
Relevant to	All Trust staff		
Date published	March 2019		
Implementation date	March 2019		
Date last reviewed	February 2019		
Next review date	February 2021		
Policy lead	Malwina Paulus, HRBP and Head of ER		
Contact details	Email:Malwina.paulus@candi.nhs.uk	Telephone: 020 3317 7183	
Accountable director	Director of HR & OD		
Approved by (Group):	Joint Policy Sub Group March 2019		
Approved by (Committee):	Workforce Committee March 2019		
Document history	Date	Version	Summary of amendments
	May 2009	1	New Policy
	September 2012	2	Complete rewrite of Version 1
	March 2014	3	Policy Reviewed
	April 2016	4	Policy Reviewed - added reference to HR Investigation policy and procedures
	March 2019	5	added timeframes of grievances, involvement from ER Team at early stages
Membership of the policy development/ review team	HR Staff Members of Joint Policy Sub Group		
Consultation	Members of Workforce Committee Members of Joint Policy Sub Group		

DO NOT AMEND THIS DOCUMENT

Further copies of this document can be found on the Foundation Trust intranet.

Contents

1. INTRODUCTION

1.1 Grievances are concerns, problems or complaints relating to your employment that you wish to raise with management. Camden & Islington NHS Foundation Trust (the "**Trust**") recognises that from time to time you may have a grievance that you want to be addressed and if possible, resolved. The Trust will try to resolve, as quickly as possible, any grievance you have connected to your employment.

1.2 The Trust believes that it is a mutual benefit to the Trust and its employees to work in partnership with Staff side. This policy has been developed and agreed by management and Staff side, in order to ensure staff are treated consistently and fairly.

1.3 This policy does not form part of any employee's contract of employment and the Trust may amend it at any time.

2. PURPOSE

2.1 This policy provides a framework within which an employee may bring a grievance arising from their employment and is aimed at resolving that grievance. It is designed to ensure that grievances are treated objectively, sensitively, consistently and fairly, and that an effective conclusion is reached in a timely manner.

3. SCOPE AND PRINCIPLES

3.1 This policy applies to all employees of the Trust, including medical staff, regardless of role, location or contractual status. Further details are set out below in respect of collective grievances (see paragraph 6). The Trust will only consider grievances about issues no older than three months except in exceptional circumstances.

3.2 All parties are required to adopt a reasonable and responsible attitude, respecting the other's dignity, in the operation of this procedure and make every effort possible to resolve differences at the informal stage. The use of the formal stage should be a last resort.

3.3 The Trust encourages informal resolution of grievances, however if an employee wishes to raise a grievance formally, they will need to do it in writing using the form in appendix C.

3.4 Issues that could cause grievances may include:

- Changes in terms and conditions of employment
- Perceived/actual breaches of health and safety
- Poor work relations
- Introduction of new working practices
- The working environment
- Organisational change
- Perceived unfairness/ breach of equal opportunities

3.5 This Grievance Procedure should not be used to complain about dismissal or disciplinary action (whether related to discipline, absence, capability and/or any sanction imposed) and/or any job evaluation, grading or nationally set terms and conditions applicable to employment (unless it is a local interpretation of the national

T&Cs). If an employee is dissatisfied with any disciplinary action, they should submit an appeal under the appropriate procedure, which is available from the Intranet.

3.6 The Trust:

3.6.1 has a separate Anti-Harassment, Bullying and Discrimination policy that should be referred to if an employee believes they have been a victim of bullying, harassment or discrimination or wish to report an incident of bullying, harassment or discrimination involving other people. It is available from the Intranet or the Employee Relations (ER) Team; and

3.6.2 operates a separate Raising Concerns at Work Policy to enable employees to report suspected illegal activities, wrongdoing or malpractice. However, where an employee is directly affected by the matter in question, or where they feel they have been victimised for an act of whistleblowing they may raise the matter under the Grievance Procedure.

3.7 If, after following the procedures referred to above, the complaint has not been resolved, the formal stages of this Grievance Procedure should be used.

3.8 The Disciplinary Policy deals with how employee grievances raised during a disciplinary process will be dealt with by the Trust. Please refer to section 13 of the Trust Disciplinary Policy.

3.9 Where a grievance is brought by an employee, this will not normally stop any changes from being made; however if the grievance is about a fundamental change to pay and/or the terms and conditions of the contract of employment (except where an administrative error has occurred in the application of the employee’s terms and conditions and this mistake must be rectified), the status quo may apply, pending resolution.

3.10 All stages of the Grievance Procedure will be dealt with within a reasonable timescale, unless there are special circumstances justifying a longer timescale.

3.11 Written grievances will be placed on an employee’s personnel file (the employee who raised the grievance) along with a record of any decisions taken and any notes or other documents compiled during the grievance process.

4. ROLES AND RESPONSIBILITIES

Individual Employees

4.1 Employees are responsible for conducting themselves in a professional manner at all times.

4.2 If an employee raises a grievance, they are expected to contribute to the resolution in a proactive way.

4.3 If an investigation is required either in relation to a grievance raised by an employee or a colleague, all parties will be required to participate as fully as required in a timely and constructive manner.

4.4 It is advisable for an employee to speak to their trade union representative prior to submitting a grievance so that they can receive advice and be supported from the outset. Contact details for the three main unions recognised by the Trust are as follows:

Unison:	020 02076854009
RCN:	0345 772 6100
Unite:	020 3371 2046

4.5 The employee will have the right to accompanied in accordance with this Grievance Procedure at the grievance meeting and any appeal meeting (see paragraphs 5.13 to 5.16 below). If an employee is accompanied by either an accredited Trade Union representative or a workplace colleague (the "**Companion**") in the formal stages of this Grievance Procedure, it is their responsibility to arrange for them to be present. Where possible, the Employee Relations Team and/or the manager will agree the date and time of the meeting in advance with the representative.

4.6 If you are invited to attend meetings under the Grievance Procedure as a witness you are expected to participate but you do not have the right to be accompanied This may, however, be requested in extenuating circumstances at any stage of the procedure with permission of the investigating manager or panel chair.

Managers

4.7 Managers are responsible for ensuring that any grievance raised with them is taken seriously and is dealt with in a fair, timely, supportive and constructive manner.

4.8 Should a manager appoint an investigating officer, they must ensure that they are given the appropriate time to undertake and complete a thorough investigation in a prompt and timely manner.

4.9 Managers have a responsibility for ensuring that any concerns raised are resolved as quickly as possible, and particularly where there has been an investigation.

4.10 Managers are jointly responsible for seeking resolution in a timely and constructive way and for ensuring the actions on any agreed action plan are carried out.

4.11 Managers are required to grant reasonable time off to accredited trade union representatives to represent their members under the Grievance Procedure in accordance with the Time Off for Trade Union Duties Policy

Accredited Trade Union Representatives and Workplace Companions

4.12 The role of the accredited trade union representative or workplace companion is to:

- advise and support, as well as to offer independent scrutiny of the Trust's Grievance Procedure for the employee raising a concern.
- accompany and represent employees at any formal meetings under this Grievance Procedure. In exceptional circumstances and by prior agreement with the manager, they may accompany employees at informal meetings and/or witnesses as set out in this Grievance Procedure.
- share responsibility with the other parties to assist with resolutions in a timely and constructive way and make every effort possible to help resolve differences at the informal stage.

The Investigating Officer

4.13 The purpose of the investigation is to establish the facts and gather evidence as fully and as quickly as possible. The investigating officer is responsible for establishing contact with the employee raising the grievance for keeping them updated on the progress of the investigation.

4.14 The investigating officer is responsible for confirming the outcome of the investigation in writing.

4.15 Depending upon the findings of the investigation, the investigating officer may be required to attend any formal meetings under this Grievance Procedure.

Employee Relations Team

4.16 The Employee Relations Team will be responsible for advising all parties on this Grievance Procedure and providing specific management and staff guidance.

5. THE PROCEDURE

Step 1 –Informal grievance

5.1 Most grievances can be resolved quickly and informally through discussion with your line manager at the earliest opportunity.

5.2 If an employee feels unable to speak to their manager, for example, because the complaint concerns him or her, then they should raise the issue they are aggrieved about informally to a more senior manager within 21 calendar days of the matter , or knowledge of an issue which may have come to light.

5.3 The line manager (or next-in-line manager where appropriate) should arrange to meet with the individual as soon as possible after the concern is raised with them, to ascertain the nature of their grievance and discuss how best it can be addressed. The details of the grievance will also be shared with the ER Team in order for them to establish the grounds of complaint and support both parties in resolving matters informally.

5.4 It may be necessary for the manager to meet with other relevant people to ascertain relevant facts. The employee will be informed at the conclusion and their line manager will discuss the findings and explore options available, with a view to resolving the issue. After this stage is completed the outcome and any recommendations will be shared with the employee and confirmed in writing and shared with the ER Team for monitoring purposes.

5.5 In some cases, it may be appropriate to involve an internal mediator from management or staffside. Mediation is an entirely voluntary process for both sides and does not preclude the use of other stages of this policy if it is not successful.

Step 2 – Formal Grievance and Process

Formal Grievances

5.6 If the matter cannot be satisfactorily resolved under step 1 above, the employee should put this in writing using the grievance form available on the Intranet or from the ER Team and send a copy to their line manager. It should be submitted within 21 calendar days of the informal stage having been completed, if applicable. If the grievance concerns their line manager, the letter should be submitted to the next level manager instead. The grievance will be acknowledged within 7 working days by the relevant manager.

5.8 The written grievance form should contain clear grounds of grievance, specific examples including any relevant facts, dates, and names of individuals involved. Employees should identify desired outcomes. In some situations, the individual may be asked to provide further information. Employees will also be required to outline the steps taken to resolve the grievance informally prior to raising a formal grievance. Employees may seek assistance from their accredited trade union representative.

Investigations

5.9 In consultation with the Employee Relations Team, it may be necessary to carry out an investigation into the matters raised in the grievance. The extent of investigation undertaken will depend on the nature of the allegations and will vary from case to case. It may involve interviewing and taking statements from the employee and any witnesses and/or reviewing relevant documents.

5.10 The employee must co-operate fully and promptly with any investigation. This may include informing the investigating manager of the information set out at paragraph 5.8 above and/or attending interviews, as part of the investigation.

5.11 If the manager receiving the grievance commissions an investigation, the Trust's HR Investigations Procedure should be followed. The manager receiving the grievance will undertake the role of the Commissioning Manager and will review the investigatory report upon completion of the investigation. The Commissioning Manager is responsible for keeping the individual informed of the details and progress of the investigation. Any person subject to a complaint should also be made fully aware of the complaint and be given the opportunity to respond to the allegations.

5.12 In circumstances where the grievance is straightforward, it may be possible to refer to a grievance hearing without the need for an investigation. In other cases, after the investigation is complete, the commissioning manager will hold a grievance outcome meeting.

Right to be Accompanied

5.13 The employee may bring a workplace colleague or accredited Trade Union Representative to any grievance meeting or appeal meeting under this procedure (see paragraph 4.5 above). The employee must tell the person holding the grievance meeting who their chosen colleague/representative is, in good time before the meeting.

5.14 At the meeting, the colleague/representative may make representations to the chair and ask questions but should not answer questions on the employee's behalf.

5.15 If the chosen colleague/representative is unavailable at the time a meeting is scheduled and will not be available for more than 5 working days afterwards, the Trust may ask the employee to choose someone else.

Grievance Meetings

5.16 In order for the matter to be investigated thoroughly, the employee and their colleague/representative (if any) should make every effort to attend grievance meetings. If the employee or their colleague/representative cannot attend at the time specified, the employee should inform the person holding the grievance meeting and a member of the Employee Relations Team immediately. The Trust will try, within reason, to agree an alternative time.

5.17 A representative from the Human Resources Department will be present at the meeting. Where witness evidence is to be considered, witnesses may be called in order to give evidence. The arrangements for this meeting will be confirmed in writing.

5.18 The Trust will aim to provide the outcome of the grievance investigation at the meeting. When it is not possible, the chair will write to the employee, usually within 10 working days of the final grievance meeting, with the outcome of the grievance and any further action that the Trust intends to take to resolve the grievance. Details of an appeal process and who to appeal to will also be provided.

Step 3 – Appeal

5.19 If the grievance has not been resolved to the employee’s satisfaction, they may appeal to the designated officer as per 5.18, stating full grounds of appeal in writing within 10 working days of the date of the outcome letter.

5.20 An appeal meeting will normally be held within 4 weeks from the receipt of the appeal letter. This will be dealt with impartially by a more senior manager than the chair of the grievance meeting, who has not previously been involved in the case (although they may ask anyone previously involved to be present) (the "**Appeal Chair**"). The Appeal Chair must be at least at Band 8 level or equivalent. A senior representative from HR department will also be present at an appeal meeting and the employee has the right to bring a colleague/representative to the meeting (see paragraphs 5.13 to 5.16 above).

5.21 The Trust will confirm the final decision in writing, usually within 10 working days. The Appeal Chair's decision is final. This is the end of the Grievance Procedure and there is no further appeal.

6. Collective Grievances

6.1 Where a grievance is lodged by a group of employees, it will be dealt with and heard on behalf of the group as a whole where this is practicable. The group will elect a maximum of 2 people to present their case.

6.2 The process outlined in steps 1 to 3 will be followed for collective grievances.

7. Review of the Policy

7.1 The policy will be reviewed on a biannual basis in conjunction with accredited Trade Union representatives.

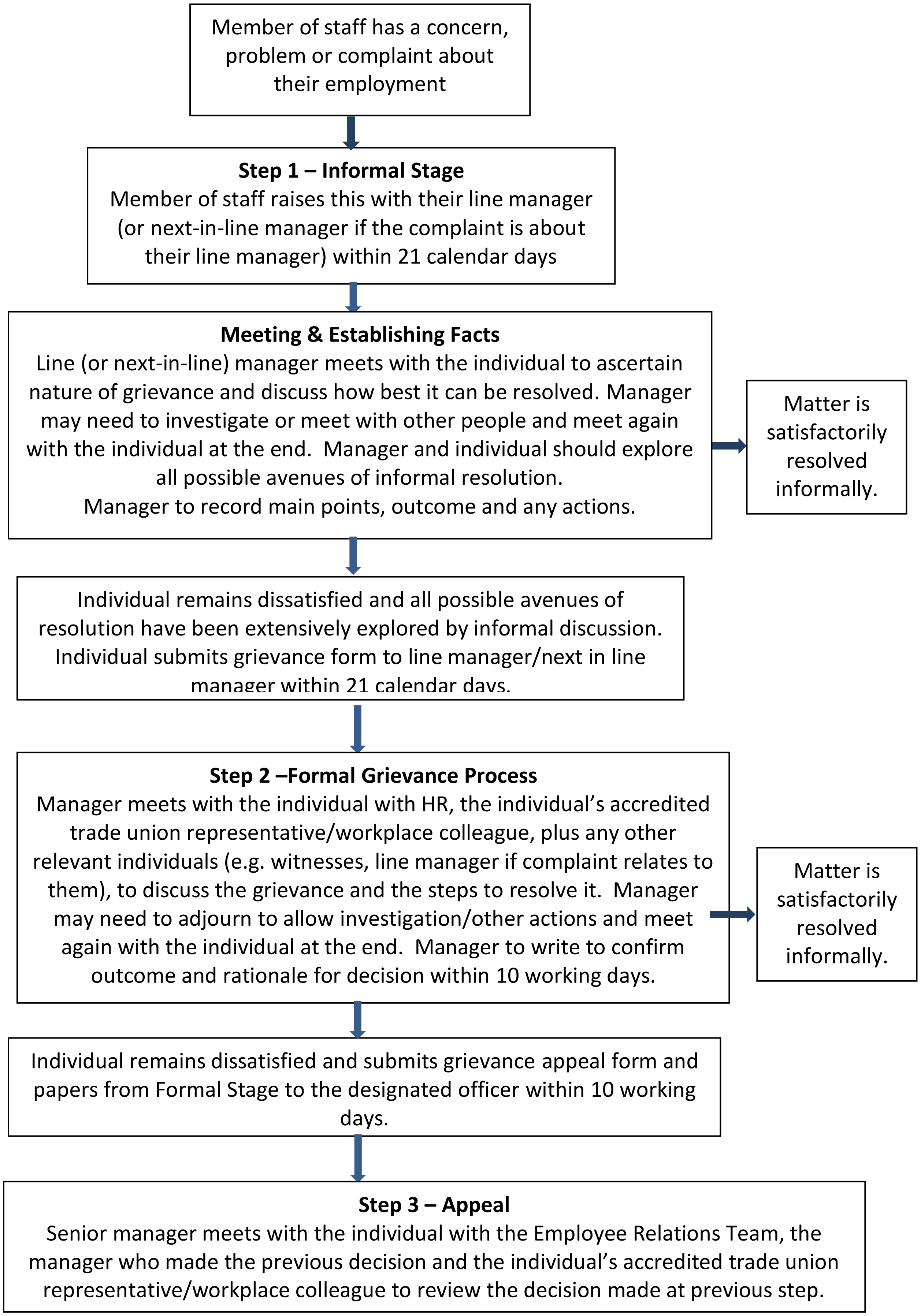
8. Monitoring

8.1 The Employee Relations Team will maintain statistics of all formal grievances raised and monitor trends by disability, age, gender (including transgender), race, religion and belief, sex and sexual orientation, marriage and civil partnership, and pregnancy and maternity. They will develop appropriate action plans if a trend becomes apparent, and will monitor the action plans for compliance on a quarterly basis. This will be reported to the Trust's Board annually.

9. Associated Documents

- Anti-Harassment, Bullying & Discrimination Policy
- Whistleblowing Policy
- Disciplinary Policy
- Time off for Trade Union Duties Policy
- HR Investigations Procedure

APPENDIX A Procedure Flow Chart



Member of staff has a concern, problem or complaint about their employment

Step 1 – Informal Stage
Member of staff raises this with their line manager (or next-in-line manager if the complaint is about their line manager) within 21 calendar days

Meeting & Establishing Facts
Line (or next-in-line) manager meets with the individual to ascertain nature of grievance and discuss how best it can be resolved. Manager may need to investigate or meet with other people and meet again with the individual at the end. Manager and individual should explore all possible avenues of informal resolution.
Manager to record main points, outcome and any actions.

Matter is satisfactorily resolved informally.

Individual remains dissatisfied and all possible avenues of resolution have been extensively explored by informal discussion. Individual submits grievance form to line manager/next in line manager within 21 calendar days.

Step 2 –Formal Grievance Process
Manager meets with the individual with HR, the individual's accredited trade union representative/workplace colleague, plus any other relevant individuals (e.g. witnesses, line manager if complaint relates to them), to discuss the grievance and the steps to resolve it. Manager may need to adjourn to allow investigation/other actions and meet again with the individual at the end. Manager to write to confirm outcome and rationale for decision within 10 working days.

Matter is satisfactorily resolved informally.

Individual remains dissatisfied and submits grievance appeal form and papers from Formal Stage to the designated officer within 10 working days.

Step 3 – Appeal
Senior manager meets with the individual with the Employee Relations Team, the manager who made the previous decision and the individual's accredited trade union representative/workplace colleague to review the decision made at previous step.

Appendix B

Equality Impact Assessment Tool

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**	No	
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

Appendix C – Grievance form

Camden and Islington
NHS Foundation Trust

FORMAL GRIEVANCE FORM

This form is to be used to raise grievance formally in accordance with the Trust Grievance Policy. Please fill it in indicating all details requested below and submit to the appropriate person, as per the aforementioned policy.

Date	
Name	
Department/Division Contact number	
Who is the form submitted to Name Job title	
Name of a Trade Union Representative (if applicable)	
What steps have you taken to resolve the issues informally	
Why were you not satisfied with the informal outcome	
Grounds for grievance – please list specific grounds, indicate detailed situations, etc.	
What outcome are you looking for?	
Any further relevant information	

the british
psychological society
promoting excellence in psychology

Supporting and valuing lived experience of mental health difficulties in clinical psychology training

September 2020

Division of
Clinical Psychology

This guidance was produced by a small team at University College London (UCL) with input from a working group of clinical psychology trainers, trainees and clinical supervisors.

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We warmly thank the following colleagues and trainees for their helpful contributions during the process of producing this guidance and wholeheartedly apologise to any contributor whose permission for being named we were not able to secure.

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Contents

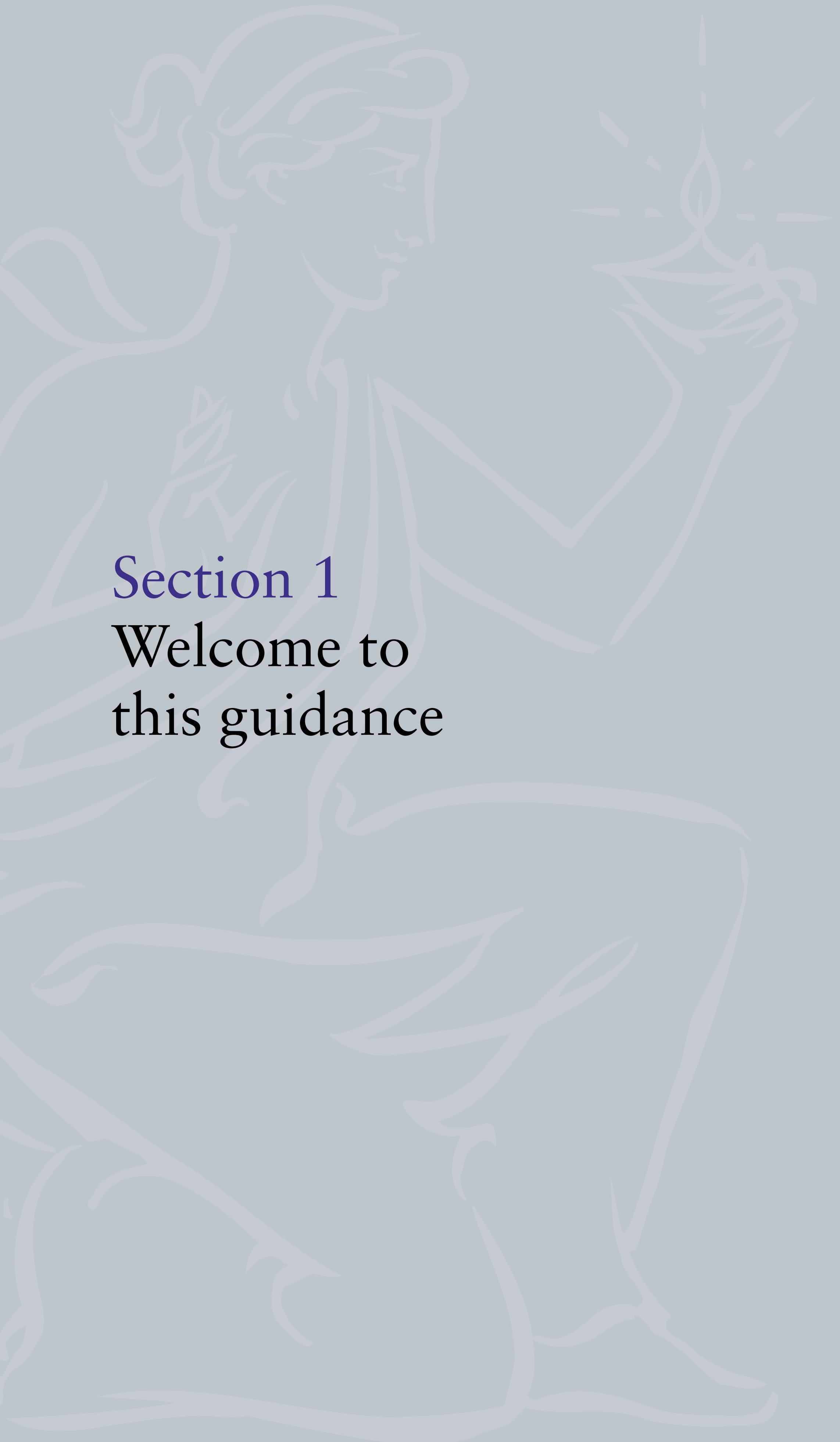
Executive summary

This document has been produced as guidance for the clinical psychology training community in order to increase the likelihood that trainees who experience mental health difficulties will be well supported. Another central aim in producing this guidance was to recognise that mental health difficulties are just as common among mental health professionals and those in training as they are in the general population, and to challenge the silence, stigma and shame that often surrounds mental health difficulties.

The guidance considers a range of complex issues that trainees, course staff and clinical supervisors may encounter and outlines what good practice may look like. It notes the importance of creating a culture of compassion and openness at course level, and within the training environment more generally, and how this might be achieved in practice. Guidance is provided on how to understand confidentiality and considerations to hold in mind when reaching decisions about sharing experiences of distress with others in the training environment and professional sphere. Detailed guidance is offered on how to support trainees who experience mental health difficulties, resources to draw on, and ways to manage instances when a trainee may need to take time out from training. It also seeks to demystify professional regulations and the rare instances when they may be drawn on, noting that a proactive approach as outlined in this guidance is always preferable to any regulatory actions.

Keeping the needs of those who seek our support central to our work, while affording both them and our colleagues and trainees kindness and compassion should be at the core of our practice and values. Central to this guidance is a belief that where mental health professionals are concerned, knowing when to ask for help and doing so is a sign of professional competence in action and not of failure. We hope this guidance and the recommendations it contains will be received in this spirit.

01



Section 1

Welcome to this guidance

SECTION

Mental health difficulties are a common human experience – they call for others' compassion and kindness, whether or not the person seeks support or tries to manage alone. Having asserted that they are a common human experience, Stephen Hinshaw, in *Breaking the Silence* (2008), drew attention to the silence that generally surrounds mental health professionals' own mental health needs. Since then, it has become increasingly recognised that mental health professionals are as vulnerable to mental health difficulties as the population at large, if not more so. Their potential increased vulnerability is due to numerous factors, not least that work in this area places high emotional demands and stresses on practitioners. In addition, individuals with lived experience of mental health difficulties may be attracted to work in the mental health field, seeking to add value to mental health service provision based on their own experiences. For some this is because they have been inspired by positive encounters with services and individual clinicians; for others, negative experiences of help-seeking have motivated them to ensure that others have more positive encounters with mental health services.

Regrettably the work culture in many services maintains an 'us-versus-them' stance and practitioners can be reluctant to engage in wider systemic conversations about their own vulnerabilities, or talk about personal experiences of mental distress. Many mental health professionals can feel pressure to appear invulnerable and to remain firmly on the side of the 'helper'. They can experience intense dilemmas when considering speaking openly about their experiences of distress or of seeking help. The perspective of experts by experience is increasingly and quite rightly sought by service providers, policy makers and researchers; however, the usual assumption is that these experts are users and not providers of mental health services. This reinforces the polarised notion of an 'us and them' divide in mental health services and does little to challenge stigma. It also diminishes opportunities for us to learn from providers who have lived experience. This guidance hopes to contribute to current efforts to challenge the stigma not only of experiencing mental health difficulties, but also of experiencing them as a mental health professional. In addition, it seeks to move away from thinking of lived experience among service providers only in 'problem' terms, and to adopt a more normalising and valuing stance.

When those training in a mental health profession struggle with their own mental health, it can evoke complex emotions and responses, both in the individual concerned and in those tasked with training them. Responding in ways that are sensitive to both service users' and trainees' needs, and promoting training environments that are empathic and containing, is not always easy. Distinguishing when things are manageable and when more help is needed is key. While this often calls for flexibility, university regulations and procedures and funding arrangements may well constrain what adjustments to usual training processes are possible. This guidance therefore seeks to provide good practice examples and information about multiple sources of support that trainees and trainers may want to consider in identifying the most helpful way to proceed at a given time.

Clinical psychologists have a responsibility and many opportunities to play a role in destigmatising mental health difficulties. This does not only extend to stigma faced by service users, but also to stigma experienced by colleagues, supervisees and trainees. Accordingly, this guidance seeks to promote a stance that normalises and values lived experience among mental health care providers and others involved in their training. It was produced by stakeholders in key roles within the clinical psychology training community in the United Kingdom: trainees, trainers and clinical supervisors, many of whom are 'experts with experience'. From the outset, and central to producing a credible document, was representation from members of the training community who identify as having lived experience of mental health difficulties. Their insights into what it is like to navigate a path through training and to call on active support have greatly enriched this guidance, extending and deepening what we know from research in this area.

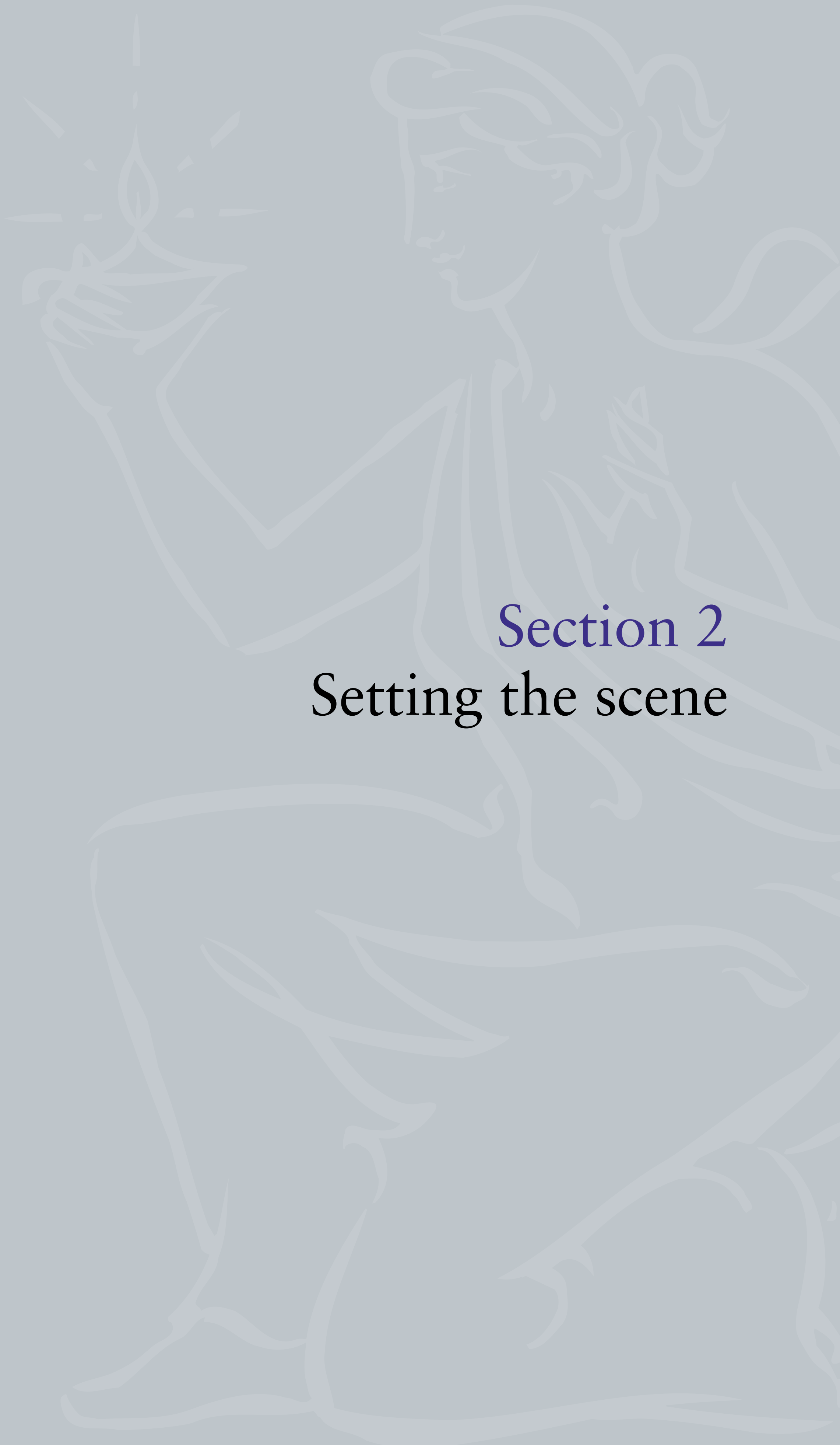
The guidance is divided into sections covering key topics relevant to the training community that we hope can be delved into as and when relevant, including:

- Ways to create a training culture that is open to and compassionate towards mental health professionals who experience mental health difficulties.
- Ways to support trainees who experience mental health difficulties.
- Factors to consider if thinking of sharing lived experience, and understanding the responsibilities and limits of confidentiality.
- Reflections on the relationship between lived experience of mental health difficulties, professional ethics and legal considerations.
- Ways to navigate time out and the return to training.
- Sign-posting to relevant policy documents and further resources.

Sample initiatives that training courses have put in place are presented throughout the guidance to offer practical suggestions, and to encourage further discussion and development among training providers.

02

SECTION



Section 2

Setting the scene

ABOUT LANGUAGE

We aim for this document to be accessible guidance to a complex area. We are mindful that the language we adopt can have a powerful impact on how we understand and relate to the topics at hand. There are many ways to describe and conceptualise personal experience of mental health difficulties. In this guidance we use the terms 'mental health difficulties', 'mental distress' and 'lived experience' in the hope to engage with the widest audience. In the interests of generalisability, we have tried to use language which is not wedded to a particular psychological model. However, users of the guidance are encouraged to draw upon diverse psychological understandings of mental health difficulties to support thoughtful and compassionate implementation. We recognise that some users of the guidance might prefer to use different terms and language. Above all, we want this guidance to be helpful to users, whatever their preferred terminology, in different contexts and relationships. We therefore welcome users to adapt the language if that would make the guidance more helpful for them.

When referring to conversations about mental health difficulties in this guidance – particularly where an individual contemplates telling someone about their experiences – we use the terms 'sharing' or occasionally 'disclosure', although we acknowledge that the term 'disclosure' has some negative connotations.

We have adopted the succinct term 'trainees' to refer to trainee clinical psychologists and hope that aspects of this guidance might be relevant and helpful to those in other mental health professions. We also highlight where important distinctions may exist between procedures for trainees whose training is funded along different routes, be this NHS funded, through an international source, or self-funded. We use the term 'course staff' to refer to academics and tutors employed by doctoral clinical psychology training programmes. The terms 'clinical supervisors' or 'placement supervisors' describe those with supervision responsibilities for trainees in the NHS or other placement settings. Where responsibilities are shared between these three key stakeholder groups, we use 'we' to indicate the whole training community, mirroring a stance of working collaboratively beyond the unhelpful 'us and them' dialogues that can easily be set up.

SCOPE AND CONTEXT

WHAT DO WE MEAN BY LIVED EXPERIENCE OF MENTAL HEALTH DIFFICULTIES?

When we refer to lived experience of mental health difficulties we mean the full range of mental health difficulties, regardless of whether the person has received a diagnosis or whether they have used public or private mental health services. Some sections of this guidance focus explicitly on current mental distress. Other sections are equally relevant to current and past lived experience, consonant with our knowledge that difficulties can be dynamic and the nature and level of support required may vary over the training period.

While this guidance talks to a spectrum of distress, it focuses on experiences of mental health difficulties and not on the effects of more everyday 'stress' on general mental wellbeing. At the same time, we wish to note the negative effects that continued and cumulative stressors can have on wellbeing and everyday functioning, and that they may well lead to mental health difficulties. The recommendations in this guidance are aligned with the staff wellbeing agenda, whilst also intending to go beyond it. Guidance on supporting staff wellbeing is relevant to all staff in focusing primarily on managing stress at work and promoting daily mental hygiene. Where training environments promote trainee and staff wellbeing and are attuned to the risks of high stress levels for mental health, this is likely to benefit all members of the training community, including those with lived experience. Paying attention to wellbeing generally though is unlikely in and of itself to be sufficient in meeting the needs of trainees who experience mental health difficulties. Whilst the staff wellbeing agenda has an important role to play in ensuring that working environments are conducive to everyone's wellbeing, it does little to challenge the fear and stigma associated with mental health difficulties that are not easily understood purely as responses to stress or that may prove lasting.

LIVED EXPERIENCE AND (TRAINEE) CLINICAL PSYCHOLOGISTS

According to recent UK figures, in the general population about four in ten adults experience a diagnosable mental health problem at some point in their lives; of these, a third have not received a formal diagnosis (Mental Health Foundation, 2016). Studies suggest that mental health difficulties are also common among mental health professionals (Grice, Alcock, Scior, 2018; Meltzer et al., 2008; Rao et al., 2016; Tay, Alcock & Scior, 2018). In one survey of 348 trainee clinical psychologists across 19 UK training institutions, 67% reported lived experience of a mental health problem (Grice et al., 2018). It is likely that these figures overestimate the incidence of mental difficulties among trainee clinical psychologists due to self-selection bias. Nonetheless, they suggest that lived experience among trainees (and similarly qualified clinical psychologists, see Tay et al., 2018) is far more common than hitherto recognised. It appears that it is not a few, but many, who have had to face the silencing effects of stigma and intense fear of 'being found out'. In a training context it is also important to acknowledge contextual factors that may make trainees more vulnerable to mental health difficulties, such as the fact that some relocate to take up training and as a result move away from established support networks.

TAKING A WHOLE-SYSTEMS PERSPECTIVE

Course staff, trainees and placement supervisors may all have lived experience of mental health difficulties. While this guidance focuses primarily on trainees, it is incumbent on all these stakeholders to contribute to creating training and clinical environments that are compassionate and that seek to destigmatise lived experience, rather than perhaps this being seen as primarily relevant to or the responsibility of trainees. We have taken the position that supporting trainees with lived experience should be a collaborative endeavor with responsibilities for the trainees concerned, course staff and clinical supervisors. Where courses embrace a culture that is open, safe, compassionate and supportive in responding to trainees' needs, trainees and other members of the training community are more likely to feel able to be open about their lived experience and to reflect on its value and impact in their work. In turn, we would hope to decrease situations where opportunities for early support might have been missed and address the paradox that we (at times implicitly) tend to give quite different messages about speaking out and seeking support to service users and members of our own profession.

THE NHS AS TRAINING CONTEXT

The risks of excessive work and stress to all health professionals' mental health have attracted increased attention recently, leading to the establishment of the NHS Staff and Learners Mental Wellbeing Commission in 2017. The Commission's final report, published in February 2019, summarised some of the particular challenges of being a learner in the NHS and actions needed to ensure that learners who experience mental health difficulties are well supported. It noted particular barriers to help seeking, such as those in the position of providing support for wellbeing are often the same people tasked with assessing learners. This common scenario is likely to increase learners' fears about the detrimental impact that sharing might have on their future career prospects. In this guidance we have therefore identified a need for greater clarity regarding the boundaries of sharing and confidentiality in training.

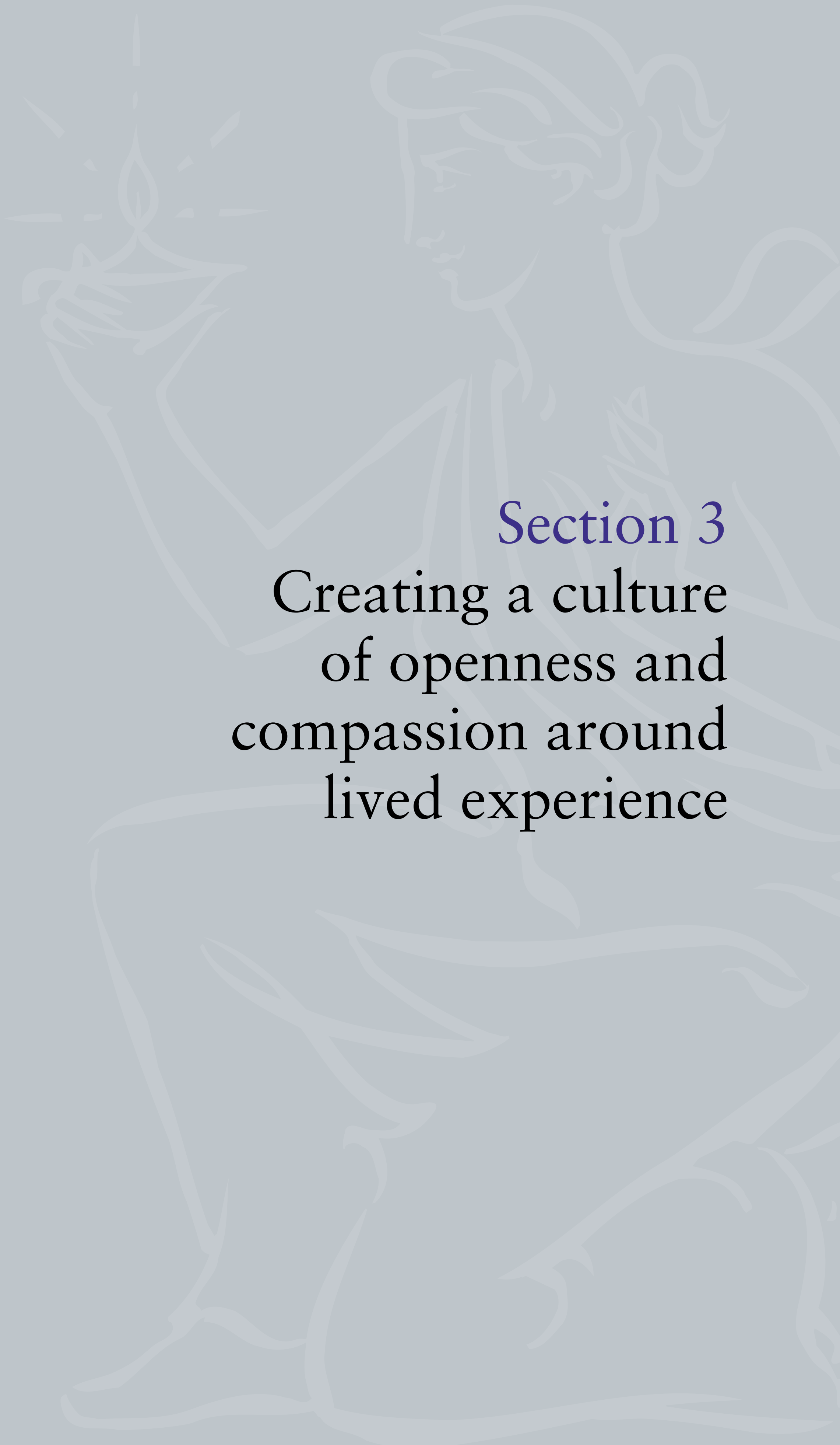
LEGISLATIVE CONTEXT

While it is beyond the scope of this guidance to set out the relevant legal context, we wish to briefly draw attention to key legislation which readers of this guidance should familiarise themselves with in order to ensure that they understand their legal rights and obligations.

Under the Equality Act 2010 it is unlawful to discriminate against disabled applicants, employees and students in admission or enrolment or by failing to make reasonable adjustments to the study or work environment. Many people with mental health difficulties do not think of themselves as 'disabled' but they may have rights supported by the Act. A person with mental health difficulties is covered under the Act if their condition has a 'substantial' and 'long-term' (defined as lasting 12 months or more) negative effect on their ability to carry out usual day-to-day activities. The Act also covers those who have experienced mental health difficulties in the past, even if they have recovered, and those whose condition is successfully managed by treatment or therapy, as long as they meet the definition above.
Universities have a common law duty of care to students. This includes provision of pastoral support and taking steps required to protect the health, safety and wellbeing of students.
Of relevance to issues of confidentiality is the Data Protection Act 2018 and the UK's implementation of the General Data Protection Regulation (GDPR). These set out regulations around the handling of data, in particular, the handling of personal and sensitive data which includes personal health data.

03

SECTION



Section 3

Creating a culture of openness and compassion around lived experience

The importance of creating working environments in which mental health and available support are discussed openly with employees at regular intervals has become increasingly recognised. The 2017 seminal report *Thriving at work,* by Stevenson and Farmer, notes that "This is not just about discussing mental health problems, but about creating an environment in which employees feel able to talk openly." (p.68)

Training institutions should champion a training environment that encourages openness to lived experience in the profession and among trainees. They should be mindful that trainees may experience shame and fear of negative consequences in relation to their lived experience; in some cases these may be informed by past negative responses when they have told others about their mental health difficulties. Some have had positive experiences of sharing at interview stage but have felt frustrated once on the course by a lack of further dialogue about what their lived experience might mean for training. Hence courses are encouraged to think more actively about how to create a culture where trainees and staff feel able to talk openly about personal struggles generally and lived experience specifically, and where those with lived experience feel that they can make a meaningful and positive contribution rather than being viewed primarily in problem terms.

HOW WE TALK ABOUT MENTAL HEALTH DIFFICULTIES

In the context of clinical psychology training, talking about mental health difficulties, past or current, is a collaborative practice involving the whole training community through creating a culture of openness and compassion. Everyone involved in clinical training should be encouraged to think about how they perceive and talk about lived experience: not just among service users, but also among colleagues and other service providers. Course staff may benefit from making time to think together about the messages they want to communicate about mental health within the profession, their own modelling around this, inviting lecturers who openly identify as having lived experience and briefing external lecturers about being open to lived experience among trainees.

Taking time to view lectures and documents through the lens of someone with lived experience can help alert training providers to implicit messages which may reinforce an 'us and them' polarity and suggest that vulnerability is only to be found 'outside the room'. Trainers should also be mindful, particularly when considering simulated and experiential components of training, of assumptions that trainees will not have experienced the issues in question personally.

Importantly, in addition to requiring trainees to undergo occupational health assessments ahead of starting their training, courses routinely ask those who have accepted a place to disclose health difficulties and disabilities that the course needs to be aware of, above all for the purpose of placement planning. Courses should consider carefully how they ask for this information and ensure that they make it clear why this information is sought, how it will be used and what the boundaries of confidentiality are.

WHAT CREATING A CULTURE OF OPENNESS MAY LOOK LIKE IN PRACTICE

Here we provide selected examples of steps that courses have taken to promote a culture of openness and to normalise lived experience.

EVENTS AND WORKSHOPS PROMOTING INCLUSIVITY

The Lancaster course held an event in 2018 focused on identities as professionals and service users/experts by experience entitled 'Humanity & Commonality: No More Them & Us' with speakers including Natalie Kemp, Rufus May and Elisabeth Svanholmer. Natalie Kemp has also provided talks, advanced reading seminars and workshops to trainees across seven clinical psychology courses: destigmatising lived experience through modelling her own navigation of lived experience as a mental health professional, and inviting reflection on the positioning of vulnerability in the mental health field and the impacts of us/them narratives.

MAKING SPACE FOR CLINICAL SUPERVISORS TO CONSIDER THIS TOPIC

Sections on supporting trainee sharing of mental health difficulties have been added as standard to all Introductory and Advanced Supervisor workshops, which are delivered by clinical tutors across the three North Thames programmes (Royal Holloway, UCL and UEL). This has the key aim to encourage new and established supervisors to be open to talking about personal struggles and lived experience of mental health difficulties, and build compassionate support for trainees. Supervisors are encouraged to be thoughtful and explicit in considering their relationship to lived experience of mental health difficulties (their own and others'), the power imbalance that exists in the supervisory relationship and to model a culture in which discussing personal struggles and potentially mental health difficulties is normalised.

NORMALISING LIVED EXPERIENCE AMONG TRAINEES

At UCL, during Year 1 induction, personal response systems (PRSs) are used to normalise lived experience, create a culture of openness and tackle stigma by allowing trainees with lived experience to see that they are by no means 'the only one'. As part of an induction workshop on the stresses inherent within training, staff model talking about emotional challenges that they have experienced and invite trainees to indicate through an anonymous 'vote' using the PRSs, whether they have lived experience. Usually at least half of each cohort respond that they have, which helps to normalise lived experience. NB: More recently the course has switched to the free software Mentimeter to complete this and similar exercises.

ESTABLISHING TRAINEE-LED LIVED EXPERIENCE PEER GROUPS

At both Salomons and UEL, trainee-led groups have been established for those with lived experience. In addition to normalising lived experience, these groups offer valuable peer support.

On other courses, such as Lancaster, trainees can request to be put in touch with other trainees who may experience similar issues for support: this can include trainees with mental health difficulties. The system is coordinated by the course's Personal Development Associate Tutor, an honorary member of staff who is separate from the course team. Smaller courses may want to consider joining with other courses to allow trainees to be part of similar schemes.

INDEPENDENT PERSONAL ADVISORS

Many training courses have independent personal advisor schemes in place. As a confidential person, who is entirely independent of the course, personal advisors may offer a helpful space where trainees can consider what personal experiences to share with trainers and how to do so.

THERAPEUTIC CONSULTATION SYSTEM

A 'therapeutic consultation' system was set up at Leicester for a period of time when funds were available. Trainees had access to three to five hours of funded consultancy space to explore an aspect of the personal-professional interface. Many who made use of this went on to engage with personal therapy to explore further. Trainees were supported to find a match in terms of person and approach, and time was given for them to attend sessions. The scheme was popular and the majority of trainees to whom it was available made use of it. Trainee feedback was that it was very helpful, not least in experiencing the help-seeking position for those who had not done so before.

SUPPORT IN ACCESSING PERSONAL THERAPY

Some, but by no means all, courses have funding for short term therapy available to trainees. Trainees who wish to access personal therapy should have information about how to access this through their university readily available to them. Those who wish to access personal therapy privately often greatly value guidance or support in accessing this. Some courses publish information about organisations and networks through which personal therapy can be accessed. Others, such as Lancaster, have a database of therapists, which can be accessed through the Personal Development Associate Tutor (see above). While expectations and support for personal therapy vary between training courses, it is our view that when and where trainees access therapy should always be a personal choice.

MAKING PLACEMENT AND RESEARCH DECISIONS AROUND THEMES OF PERSONAL RESONANCE

A culture of openness and normalising is also of great importance at points during training when decisions need making, for example around what thesis topic and research methodology to opt for or what clinical placements to pursue. Throughout their training, trainees (and trainers) may face times when such decisions may bring trainees close to their own lived experience. There are no ‘standard’ responses to such situations – some people are happy and well placed working in areas they have lived experience of themselves, and may have considerable experience of doing so before coming on the course. Others may prefer to work in areas that are far removed from their own experiences. Whatever choices are made, it is important to consider from early on, in discussion with tutors, that some lived experience themes may resonate across various placement and research areas and how this may affect the trainee, clinical work, research, and the course of training at various points. Wherever possible, trainees and trainers are advised to discuss any themes of personal resonance together ahead of making placement and research choices. It is helpful to have open conversations about the extent to which the trainee themselves feels comfortable around resonant themes, any past experience they have of working more or less comfortably around them and any potential impact on the trainee, service users or research participants of doing so. It should also be taken into account that any potential impact could be somewhat magnified at times of high demands and stress. Where the trainee or trainers doubt the trainee’s ability to manage certain themes of personal resonance at this stage, it would be important to consider this carefully together and caution would be advisable, with alternative options considered instead. If the trainee is interested in working in areas of personal resonance in the future, they could identify this as a part of their personal and professional development plan to be reviewed.

Such conversations and planning should be informed by a conviction that bringing knowledge of the self to inform decisions about placements and/or research shows reflective skills and competence. They must avoid conveying a sense that by making decisions *not* to pursue something a trainee is ‘not good enough’.

Of course there may well be occasions when it is not possible to predict in advance when people we work with may bring material that has personal resonance; open conversations from early on will facilitate open thinking about such occasions.

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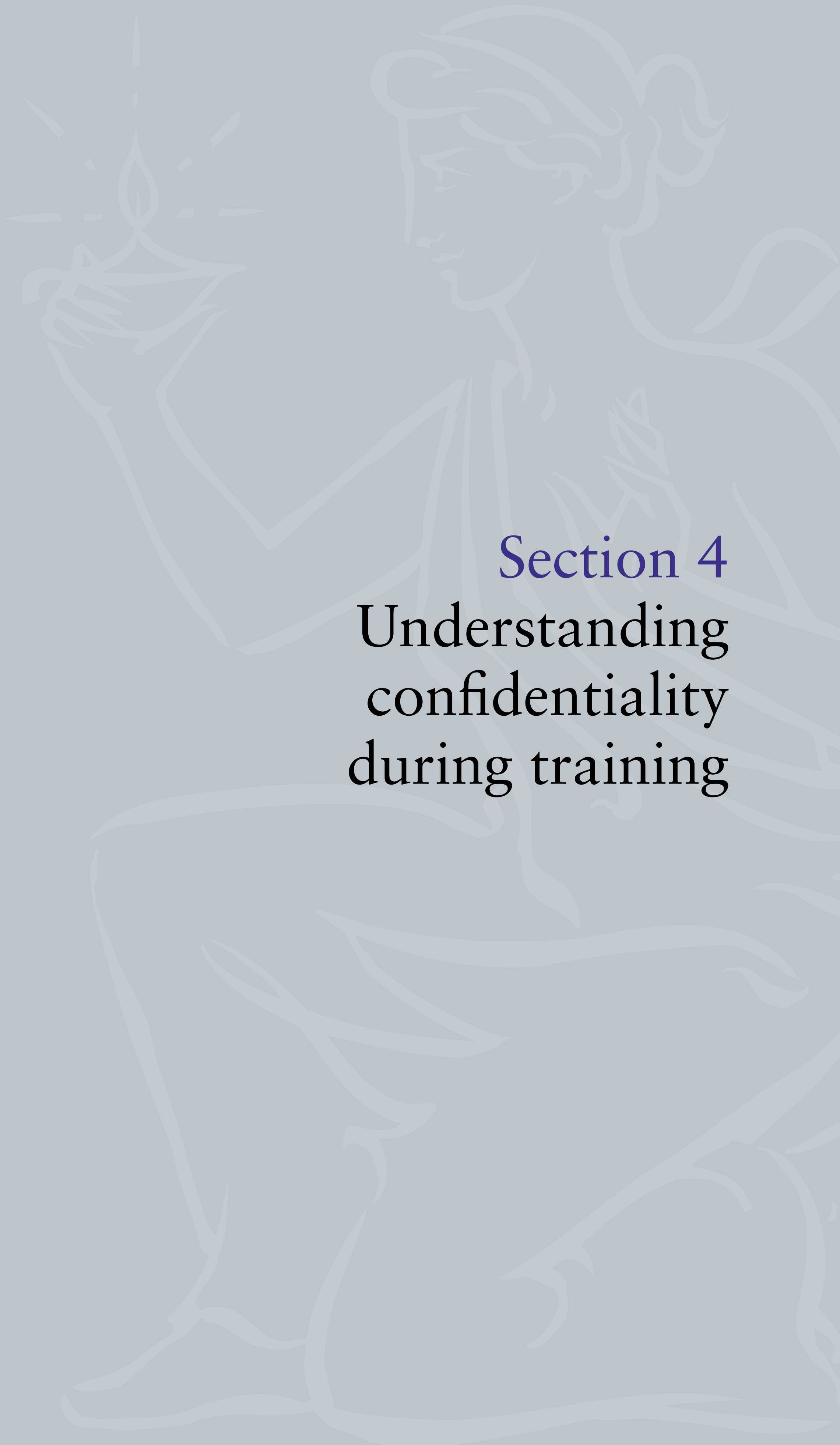
SECTION



Section 4

Understanding confidentiality during training

Many people are understandably concerned regarding who knows what when they share personal information, including about their mental health. In deciding what to share when and with whom, it is important to be clear regarding boundaries of confidentiality. In this section we therefore look at guiding principles governing confidentiality when a trainee experiences mental health difficulties.

NEED TO KNOW

A key guiding principle in relation to confidentiality and mental health difficulties is that only those people who need to know should be informed; in other words, information about mental health difficulties should only be shared with others if there is a need to do so.

Wherever possible a trainee should be made aware when information is being passed to someone else and why this is being done. Trainee consent should be sought for this, although consent may not always be needed; for example, where there is a significant risk to self or others and consent cannot be sought, or it is sought under these circumstances and withheld.

What needs to be shared and with whom should be reviewed regularly; for example, a trainee may have needed support for mental health difficulties early on in their training, but this may no longer be relevant and may not need to be shared with later supervisors.

POLICIES

All trainees are students within a university setting and also either employees or honorary employees of an NHS Trust or other organisation. Each course must therefore consider the following: university and course policies on student mental health difficulties and confidentiality, where applicable the employer's policy on mental health difficulties and confidentiality, and potentially the placement's local policy on mental health difficulties and confidentiality.

Trainees cannot be expected to understand how these various policies may interact and, as set out below, it would be helpful for each course to have a clear confidentiality statement in relation to confidentiality and mental health difficulties.

The University Mental Health Charter (Hughes & Spanner, 2019) is a helpful document for considering the importance of being explicit with students about confidentiality and its limits, and also gives some helpful guidance in relation to information sharing.

BEING EXPLICIT ABOUT CONFIDENTIALITY AND ITS LIMITS

Whilst trainees are trained to be very clear and explicit about confidentiality and its limits when working with clients, the rules around confidentiality and its limits in relation to sharing their own mental health difficulties with people involved in their training are sometimes not clearly set out. This lack of clarity may discourage trainees from sharing their mental health difficulties and may add to a fear that sharing will result in something bad happening, for example being forced to withdraw from training. In fact, withdrawal from training is a rare event and the most common outcome is that the trainee gains access to help and support. It would be helpful for courses to have a clear confidentiality statement in relation to health and personal difficulties that trainees may experience (including but not limited to mental health difficulties) so that respect for confidentiality and the limits of it are clear. It would be good practice for this confidentiality statement to be given to all trainees as early as possible and for its contents to be covered in their training induction; it should also be circulated to all other relevant people involved in training. Whilst each course will need to draft the wording to fit its particular context, the confidentiality statement should cover the following:

Respect for confidentiality and the guiding principle of 'need to know'.

Summary of the relevant policies covering confidentiality with links to those policies. This summary will need to make clear that some contexts in which information is disclosed, for example, placements, may have different professional/legal obligations regarding confidentiality.

Reference to a clear course policy about information sharing between trainees, course staff including administrative staff, placement supervisors and placement staff, employers/honorary employers, and Occupational Health.

What will happen if a trainee shares a past or current mental health difficulty with the following people?
(a) another trainee
(b) their tutor
(c) another member of staff, including administrative staff
(d) a supervisor
(e) another person on placement

Specifically, will the information remain confidential or will it be shared with someone else, and if so with whom, how and on what basis?

What will happen if a trainee, tutor, another member of course staff, a supervisor or another person on placement is concerned a mental health difficulty may be affecting a trainee's ability to function / train / practise – how will that concern be raised and how and where will it be recorded and with whom will it be shared?

When it would be necessary to consider referring a trainee to Occupational Health, how this referral works and what information Occupational Health will share and with whom.

When confidentiality will be broken, both with and without consent (for example when the trainee is considered to be a risk to themselves or others), and how it will be broken, i.e. who will be told what and how will the trainee be informed? It may be helpful to include a section on dealing with a crisis.

Where information shared is recorded, how it is recorded, who has access to that information and for how long it is held.

What information will be shared and with whom about mental health difficulties and absences (if any) beyond the course. For example, if asked for a reference, what information will the course/course staff share?

Procedure for sharing confidential information about mental health difficulties. Some trainees may be reluctant to share information with a particular member of staff and where a procedure is in place for sharing information with a particular member of staff, for example with a course tutor, there should be a clear alternative member of staff whom the trainee can approach instead.

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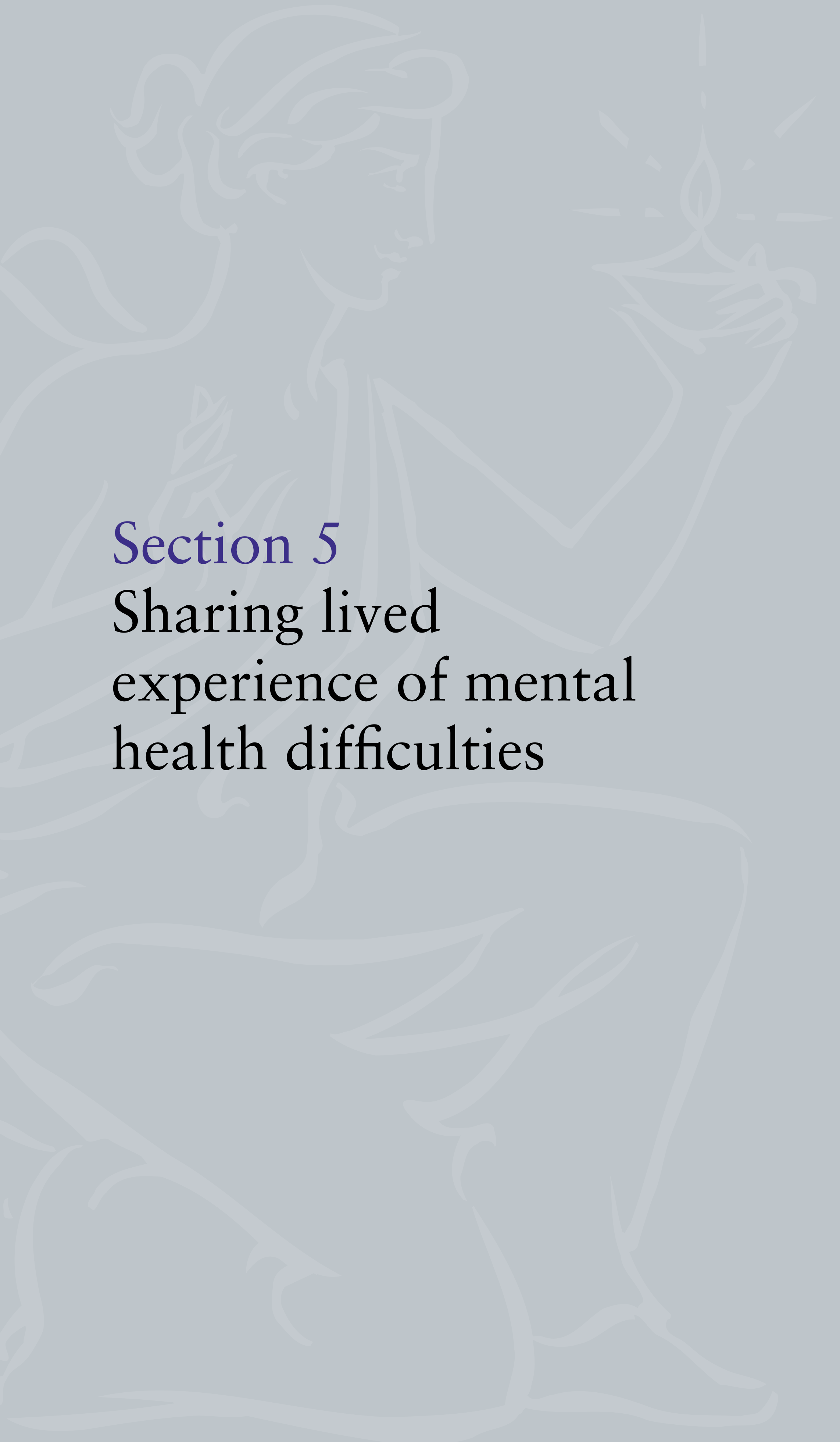

Section 5
Sharing lived experience of mental health difficulties

SECTION

DECIDING WHETHER, AND IF SO HOW AND WITH WHOM, TO SHARE LIVED EXPERIENCE

Sometimes trainees may not have a choice about having to disclose their lived experience, for example where it is adversely impacting on their clinical work. This section of the guidance addresses the common situation in which a trainee can choose whether or not to disclose their lived experience.

Trainees face difficult decisions about whether, and if so how and with whom, to share aspects of or all of their lived experience during training. A trainee may decide to disclose within one context, for example to a fellow trainee, but not in another, for example to a supervisor on placement where their lived experience is clearly not impacting on their clinical work.

Any decision to share needs careful consideration and there is no one-size-fits-all answer to the question about whether, and if so how and with whom, to share personal experience of mental health difficulties; it is for each individual to consider what the right decision might be for them at any given time and in different contexts. It can take a lot of strength to share, and the costs and benefits need to be weighed up in the knowledge of mental health stigma and recognition that sharing is not a one-off decision and act, but a continued negotiation over time. The decision to share may be driven by a need for help and support, but it may also, or alternatively, be part of personal-professional development and/or a way of actively challenging stigma.

RESOURCES TO HELP MAKE DECISIONS AROUND SHARING

There are a number of resources which may help trainees reach decisions around disclosure. We recommend that courses ensure course staff and supervisors, as well as trainees themselves, are familiar with these resources so that everyone in the training community is mindful of decisions trainees may face and can help support them.

Heads up, an Australian organisation, have produced helpful resources and guidance for employees to plan a conversation about their mental health difficulties with someone at work. This website also has free tools to help someone weigh up the potential benefits and costs of disclosing a mental health problem at work, and videos of people talking about their experiences of talking to supervisors and colleagues.

Conceal or Reveal: A guide to telling employers about a mental health condition (CORAL), is a short practical guide to help employees reach a decision about telling an employer about their mental health difficulties. The guide provides helpful exercises to guide someone through the process of considering different aspects of sharing their lived experience in a work context.

Honest, Open, Proud is a peer-group programme which aims to help people with lived experience make empowered disclosure decisions. The manual which guides the programme is freely available online and it comprises useful sections which may help someone in weighing up the potential benefits and costs of sharing, consider different ways in which they might share and how others might respond, and a detailed guide with a template on how to tell one's story.

Isolation is commonly reported by mental health professionals with lived experience and trainees may find it helpful to link in with other professionals with lived experience:

in2gr8mentalhealth offers a private and moderated members-only forum, and one to one and group mentoring for mental health professionals with lived experience. They also offer wider consultation and training to the mental health scene and host public anti-stigma campaigns on provider lived experience.

SHARING ON SOCIAL MEDIA

Social media have played an important role in promoting more open conversation about mental health and anti-stigma campaigns, such as Time to Change use social media to reach large and diverse audiences. Public campaigns on social networking sites such as The Only Us campaign and in2gr8mentalhealth's Twitter feed play an important role in challenging the stigma of mental health difficulties amongst mental health professionals. Some trainees come into training with prior experience as peer workers, and in these and other roles may have used social media effectively to raise awareness, campaign for user rights and/or encourage peer support.

Having said that, trainees and those who support them need to be mindful that sharing lived experience on a publicly available social networking platform may by default mean disclosure to colleagues and service users. The BPS Ethics Committee has published guidance on use of social media: links to the full guidance can be found in the resources section, but the following are of note:

Practitioners should remember that social networking sites are public and permanent. Once something has been posted online, it remains traceable even if deleted later on.

Practitioners should protect their privacy and consider the kinds of information that they want to be publicly available about themselves. They should ensure that they regularly check their privacy settings on social networking sites.

We recommend that courses ensure that trainees and those who support them are aware of this guidance and are able to reflect thoughtfully and carefully about the pros and cons of a trainee being public about their lived experience.

SHARING LIVED EXPERIENCE IN THE THERAPEUTIC RELATIONSHIP

Different psychological approaches have different views about therapist disclosure of lived experience within the therapeutic relationship. However, most therapeutic approaches caution against such disclosure, or suggest it should only be done in relation to a specific client after being carefully discussed and agreed to be clinically helpful within supervision, with the focus at all times remaining on client need. Research into the impact of sharing lived experience with clients in the therapeutic relationship is in its infancy but suggests it is important carefully to weigh up potential risks as well as benefits (Lovell, 2017).

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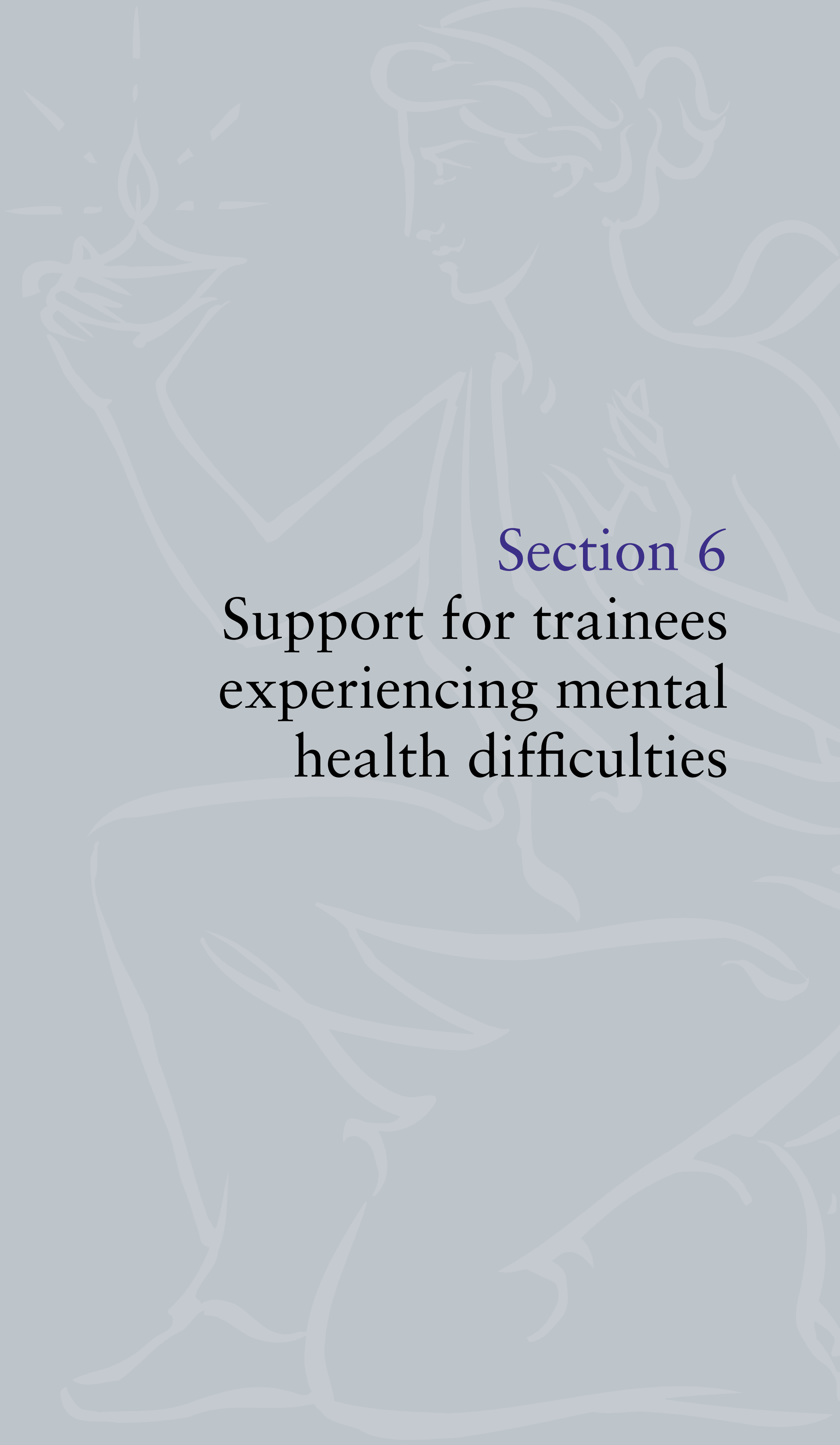

Section 6

Support for trainees experiencing mental health difficulties

There will be many occasions when trainees may experience mental health difficulties but manage these well with or without support from course staff, placement supervisors or indeed peers. Differentiating between such occasions and times when there may be a need for additional support or 'intervention' is likely to be much easier where there is a culture of openness from the outset and where trainees have been able to develop trusting relationships with course staff.

Even where trainees feel able to talk about their lived experience and are able to access support as and when needed, there will be occasions when trainees experience mental health difficulties that may affect their ability to function in training. This section seeks to offer guidance for occasions when a trainee experiences acute distress, whether the trainee identifies this first or someone else does.

It is important to respond promptly and compassionately in the event of mental distress, yet to refrain from reacting too quickly or decisively. Often an initial period of active monitoring in discussion with the trainee and relevant stakeholders will be most appropriate, paying close attention to transparency around confidentiality. Guidance from experienced members of the system should be sought where possible, and any decisions and actions tailored to the specific trainee and context. Agreeing what support is needed and who should provide this should be a shared responsibility between the course, the trainee, their placement supervisor, and employer, where appropriate. Both the trainee and service users should be kept at the heart of thinking and everyone's responsibility to safeguard service users must be taken seriously at all times. Where there is concern that a trainee is not able to meet service user needs at a given time, an interruption to training may be called for (see Section 7).

How concerns about a trainee's mental health first arise, and who they are initially raised by, will affect how conversations proceed. The majority of the time trainees and course staff or placement supervisors —depending on who is involved in initial conversations about a trainee's mental health — will make decisions together about what is helpful to share, and with whom, and what the process for sharing will be. As summarised in section 4, it is essential that confidentiality is attended to clearly throughout any support process. Trainees who are in placements within the same trust as their home, for example, may well have understandable concerns about confidentiality when accessing support. As far as possible, 3- or 4-way-conversations between the trainee, course staff, supervisor, and occupational health, where involved, are encouraged to support a transparent, tailored and integrated approach. They should also be mindful that there will be lots of different relationships that may need thinking about – some of these may cross usual boundaries and require thinking about sensitively on a case by case basis, for example, where a trainee receives support from a clinical service in which one of their peers or a lecturer is located. Furthermore, the peer environment will need careful thought, and trainees should be involved in deciding what their peers are told, for example, about extended periods of absence.

It is important to consider in some detail the experience of the trainee during the process and ways to ensure that processes do not inadvertently add to their distress or become barriers to open dialogues, for instance, in needing to have multiple conversations about absences. For trainees it will be important to know how and to whom to communicate information pertaining to their current difficulties, including who to inform if they need to take a day off sick and how much detail to go into. It will often be helpful if trainees are required to communicate details only to one trusted person while notifying others in general terms, without having to give details, for example of the reason for an absence.

It is recommended that important conversations are documented in clear language, are collaborative and include agreeing when and with what frequency to review any decisions made, and who communications are shared with.

SOURCES OF SUPPORT

We encourage courses (and their hosting institutions) to provide information about the range of sources of support available to trainees at the outset of training, and to update this regularly. It is hoped that such information is communicated in different ways, including during introductory sessions, written information and within 1-to-1 conversations. We encourage courses to design such information to be accessible and approachable to those who may be anxious or in distress when referring to it. In some universities student support services, including student mental health services, attend during induction to allow students to put faces to names.

Sources of support that should be considered include:

Counselling or personal therapy via the NHS, their employer, the third sector and privately.

GP consultation to access medication and/or psychological treatments.

Mentors and Independent Personal Advisors.

University based support systems (many universities and organisations such as Student Minds provide comprehensive information about sources of support for students).

Online sources of information, including ideas included in our reference section.

Informal and peer support (some courses and NHS trusts have lived experience peer support groups).

Access to information about Union support.

Courses and placement trusts may also wish to consider helpful models, such as appointing mental health advocates or champions within course and placement contexts. It is hoped that courses can continue to learn from each other and share different models.

In thinking about sources of support, courses should be mindful that many trainees will have moved either from a different part of the UK or a different country altogether, and therefore may not have a local support network, particularly earlier in training. However, trainees may also know from past experience how best to form the support they need and their support needs should be openly discussed and not assumed.

MAKING REASONABLE ADJUSTMENTS

Decisions about referring to NHS occupational health services and/or university based student support services in order to identify what adjustments may be called for will of necessity be locality based and should be clarified at local level.

Identifying and making reasonable adjustments will often be a shared responsibility between multiple stakeholders, i.e. the trainee, course, university, host employer, placement provider and supervisor. As set out in section 2, whether a mental health problem fulfils the definition of a disability or not, it is advisable to consider whether there are reasonable adjustments which could reduce the pressures on a trainee's mental health and support them to meet training demands. Wherever possible, any adjustments should only be made following discussion and agreement between trainee, course staff and where relevant the placement supervisor about both what might be helpful and what is possible. It may also be necessary to consult with those providing health support to the trainee (of course with the trainee's consent) and with occupational health. Once an adjustment has been agreed, this should be documented and shared with all on a need to know basis. Adjustments should be regularly reviewed as to whether they are helpful or necessary and any changes documented and communicated.

Adjustments may come in many forms and there is not a one size fits all but they may include:

Increasing the frequency or length of meetings with a course tutor or placement supervisor.

Adjustment to teaching and/or placment hours to temporarily reduce demands, avoid having to travel in rush hour, or to enable a trainee to take up personal therapy.

Adjustments to the allocation of placements by location (e.g. where a need for a shorter journey has been identified) or the means of transport to travel to placement.

A possible reduction, at least temporarily, to part-time hours.

Extra time for academic work (but see below).

At least temporarily tailoring the structure and contents of placements to the trainee's needs; however, caution must be exercised to ensure that this does not shift too far towards removing usual training demands and that a possible interruption should not be considered instead.

Trainees should be aware that adjustments governed by university regulations, for example, around submission deadlines for course work, may well be outside of the course programme's remit and governed by the university's extenuation process. As such, trainees and course staff are encouraged to familiarise themselves with the relevant regulations and processes.

Courses are encouraged to develop, in liaison with their Occupational Health department, guidance on how to plan, put into action and review reasonable adjustment options. It is important such guidance includes the process for the rare instance when reasonable adjustments have not met their desired intention, including how that process may overlap with any fitness to study procedures.

DEVELOPING GOOD PRACTICE

When trainees are in distress, it makes sense that the focus is on the system supporting the trainee in a compassionate manner during the acute situation. At the same time, it is important that feedback mechanisms are embedded within processes to enable the trainee and the system to learn about what support and adjustments are more or less useful. Courses are encouraged to formalise mechanisms by which good practice and lessons learnt are shared between those within the training community, maintaining attention to confidentiality.

We also encourage course staff, supervisors and trainees to consult guidance and e-learning available outside of psychology, including through Mindful Employer and ACAS and their advice for employers regarding staff who need immediate mental health support (see Section 9).

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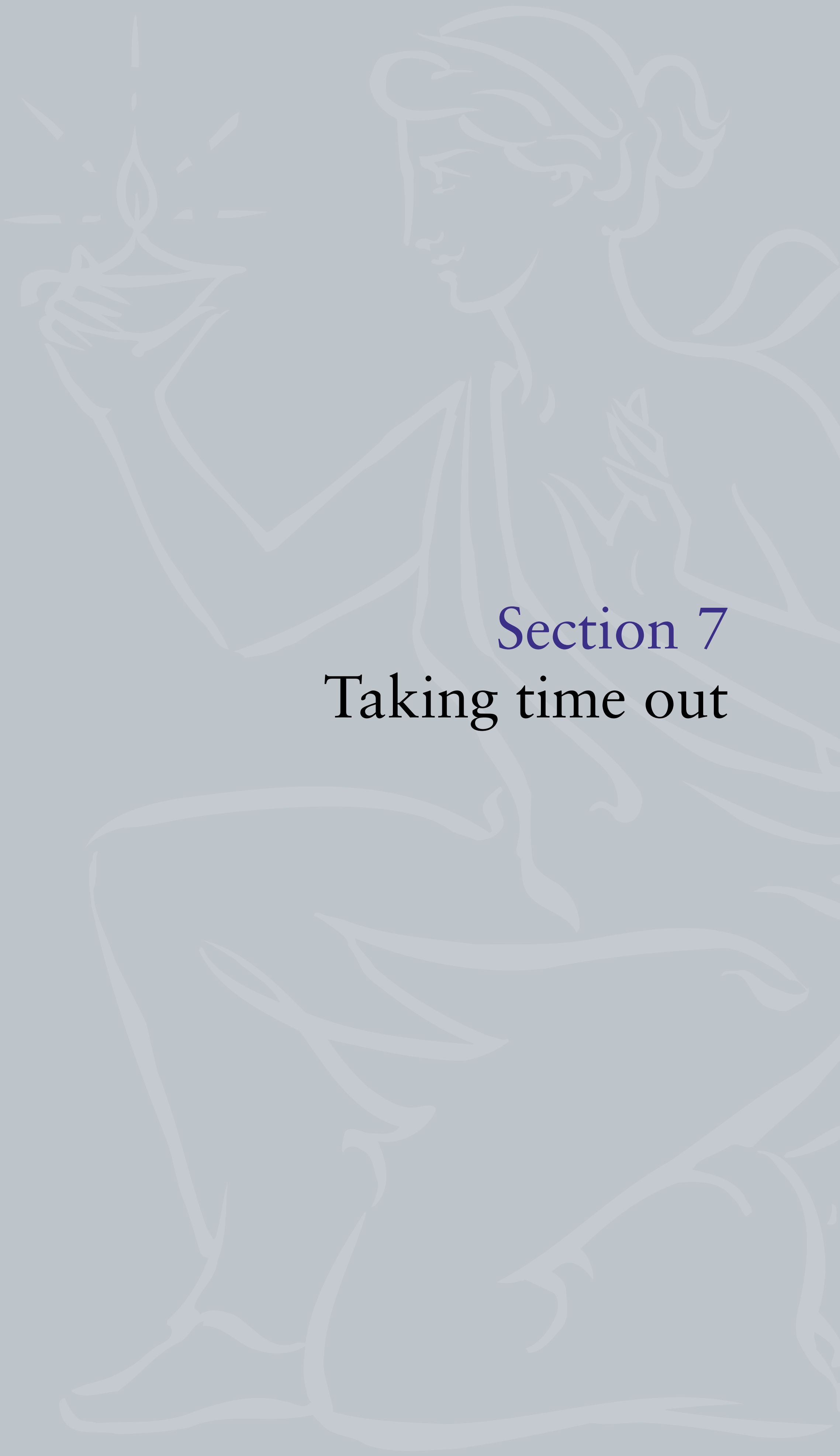

Section 7
Taking time out

A trainee in discussion with course staff may decide they need to take time out from training to attend to their own mental health. It is important to acknowledge that there can be worry about stigma around this; it is likely to be very helpful at such times to convey the message that identifying a need for time out is seen as a strength in a trainee's personal-professional development and as 'competency-in-action'.

Where an interruption is to be considered as an option, some courses will generally expect a talk with a course tutor or the trainee's line manager (usually the Programme or Clinical Director) in the first instance while others may be more flexible. If possible, a trainee should be able to approach whoever they feel most comfortable talking to initially.

Where a trainee is an NHS employee, NHS policies on sick pay apply and the trainee should consult local employment policies. Trainees who require a visa to complete training will need to understand the implications of an interruption on their visa status and will likely need support in negotiating an interruption.

If a trainee does take time out, it can help to think through what they would like the course to share with peers and other staff about their period of interruption, and if they are happy for peers to be in touch: some trainees value contact, while others prefer a rest from it. Due to confidentiality, usually a trainee's peers on the course would not know why a trainee is interrupting unless the trainee chose to inform them themselves. What is or is not communicated to others needs to be carefully negotiated with the trainee and their choice respected. When a trainee is absent, check-ins can help the course to understand any changes to initial conversations about what can be shared with others on the course.

Crisis moments can happen and there can be little time to talk through sharing considerations as outlined in Section 4. It is for courses to consider the guidance on confidentiality and sharing in this document in parallel with local guidance, and embed procedures that safeguard the trainee's privacy to only those who are identified as needing to know, and who have the responsibility of keeping in supportive contact during an interruption.

KEEPING IN TOUCH

When a trainee is taking time out it can be useful to have a single link person as a point of contact and not to have to worry about keeping on top of different communications, for example between the training course and placement.

In general it is helpful to agree with the trainee the extent to which some time is needed completely away from training, when and how to check-in for reviews and to ascertain when the time is right to start planning ahead. A discussion could include preferred format (in person or by phone or by video call) and frequency of contact, the best day and time of day, what to discuss (and perhaps what not to discuss), and how contact is feeling.

RETURNING TO TRAINING

Coming back into training is an important transition for a trainee and presents a key opportunity to show that value is seen in lived experience. Conversations may include how the trainee is doing, how effective any continuing support is and also hearing trainee reflections on their time away and what they might want to take forward into their professional life.. This would generally be done with the support of Occupational Health and possibly also the University's Student Disability Service. It can be helpful for trainees and course tutors to think together about the following aspects:

What kinds of work may call for some additional support.

What hours feel workable initially and how these can be increased over time. Where Occupational Health recommend that a trainee returns to work part-time to facilitate the return to work, trainees should be made aware that this is likely to have an impact on their salary if they have a funded place.

If adjustments are needed to deadlines or exams, this would usually fall under the University's Student Disability Service who may issue a SoRA (Statement of Reasonable Adjustments). A trainee looking to return to training should contact the service for an appointment as early as possible once they know their planned date of return.

If re-starting a year with a new peer group, support to facilitate how to meet the new group and to think through beforehand what, if anything, is shared should be offered, alongside acknowledgement of how difficult it can be to join a different year group.

A safe space to discuss what personal lived experience brings to professional practice in supervision and, if wished, the possibility of sharing this with others.

These issues are often best addressed through regular planned meetings to check how things are going, discuss changes in support or adjustments, and when those may stop being necessary.

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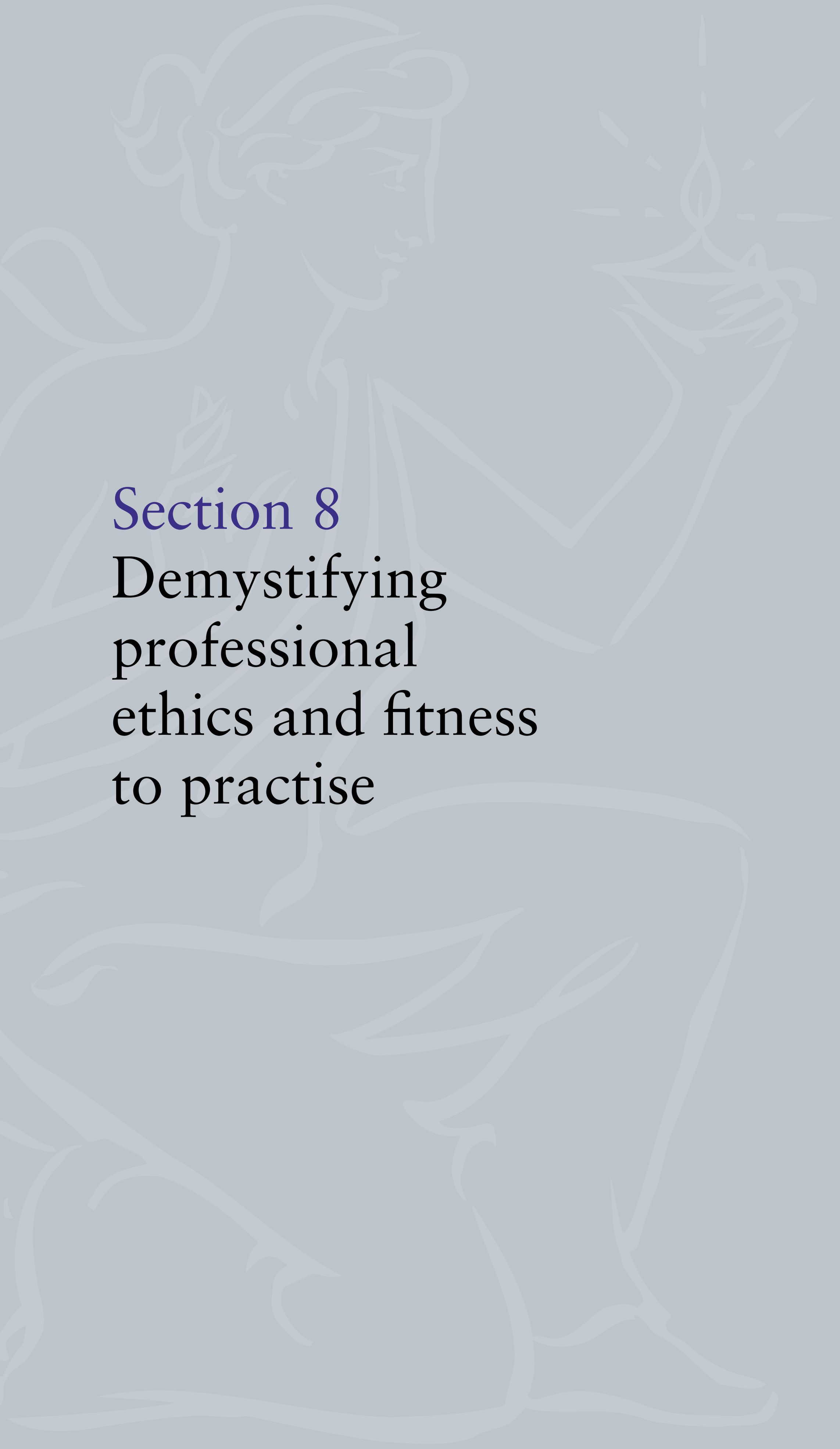


Section 8
Demystifying professional ethics and fitness to practise

SECTION

TIMES WHEN A TRAINEE HAS TO DECLARE MENTAL HEALTH DIFFICULTIES

Monitoring and responding to instances when a trainee's mental health difficulties may affect their practice is a shared-care endeavour between course and trainee. Ethical practice means that trainees should seek to recognise when they are experiencing mental health difficulties, ask for support where needed, and, if necessary, consider taking time out from training in discussion with training providers. In turn, training programmes must ensure that they provide a context where trainees feel able to come forward to discuss any need for help and that they will be met compassionately in response.

In certain circumstances trainees may have an obligation to share mental health difficulties with their supervisor, tutor or to occupational health. For example, if a course tutor or placement supervisor had concerns that difficulties in the trainee's mental health may be impacting on their ability to engage in study or clinical practice and an assessment was needed to help gain support. In line with the guiding principles of confidentiality (Section 4), the tutor or supervisor should always seek to discuss this with the trainee themselves in the first instance. It is hoped that by promoting an open and compassionate culture in the training community, and by normalising lived experience at the outset of training, such conversations would feel possible, helpful opportunities to approach them plentiful, and a mutually agreed plan of support was put in place before any obligation to share or indeed breach trainee confidentiality was deemed necessary.

Should the need to share with occupational health be necessary, it is hoped that the trainee experience of the occupational health service and liaison with the course is supportive and there is opportunity for feedback on this. Trainees can be re-referred to occupational health services if they have a period of extended sick leave.

PROFESSIONAL PRACTICE GUIDELINES

Clinical psychology training courses must meet training standards set out by the Health and Care Professions Council (HCPC) and British Psychological Society (BPS) as part of the accreditation process. They may also need to meet other professional bodies' standards, such as the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or the Association for Family Therapy and Systemic Practice (AFT). The HCPC, as the statutory regulator for practitioner psychologists in the UK, sets 'standards of education and training' (SETs) 'to make sure that learners are prepared for safe and effective practice'. The following HCPC SETs are particularly relevant to this guidance:

3.13 There must be effective and accessible arrangements in place to support the wellbeing and learning needs of learners in all settings.

3.16 There must be thorough and effective processes in place for ensuring the ongoing suitability of learners' conduct, character and health.

The BPS accreditation standards (January 2019 edition) state that programmes should support trainees to:

2.1.3.7 Develop resilience but also the capacity to recognise when own fitness to practise is compromised and take steps to manage this risk as appropriate.

5.5 Develop strategies to handle the emotional and physical impact of their own practice and to seek appropriate support when necessary, with good awareness of boundary issues. However, trainees should also have the capacity to monitor their own fitness to practise, recognise when this is compromised, and take steps to manage this risk as appropriate.

They also state that trainees who experience severe stress, psychological disturbance, or emotional upset should be given assistance in obtaining appropriate help **(5.7)**.

FITNESS TO PRACTISE

In most cases mental health conditions will not raise fitness to practise concerns, provided the trainee receives the appropriate care and reasonable adjustments necessary to study and work safely. Even then, training programmes prefer to resolve any issues before they become a matter for more formal investigation. Accordingly, and as noted throughout this guide, it is for training providers to create a culture where trainees feel able to talk about mental health difficulties at an early stage to gain any support needed. For trainees, recognising difficulties, seeking support and where necessary talking to programme staff and/or supervisors should be seen as positive courses of action that demonstrate professionalism, competence and ethical conduct and should be met as such. When qualified, considering altering or stopping one's practice if experiencing mental health difficulties over the career-span is part of dynamic and responsive good practice for all members of the profession.

It can be helpful to name the rare occasions when Fitness to Practise procedures may be invoked – depending on local regulations, these might include instances where trainees fail to seek appropriate treatment or other support; fail to follow medical advice or care plans for a chronic and serious mental health condition, including monitoring and reviews; fail to recognise current limits to their abilities.

Practitioner psychologists are also bound by the HCPC's code of conduct and ethics. The HCPC works on the principle of 'professional self-regulation', by which they mean that students who are studying to be a member of a profession they regulate, and qualified professionals, have personal responsibility to maintain and manage their own fitness to practise. The HCPC Guidance on Conduct and Ethics for Students (2016) states:

> **Managing Risk**
>
> - You should be aware that you may put your service users or yourself at risk if your performance or judgement is affected by your physical or mental health.
> - You should ask for appropriate support and adapt your study or stop studying if your performance or judgement is affected by your physical or mental health and could put service users, yourself or others at risk.
> - You should get advice from a doctor or other appropriate professional if you are worried about your physical or mental health.

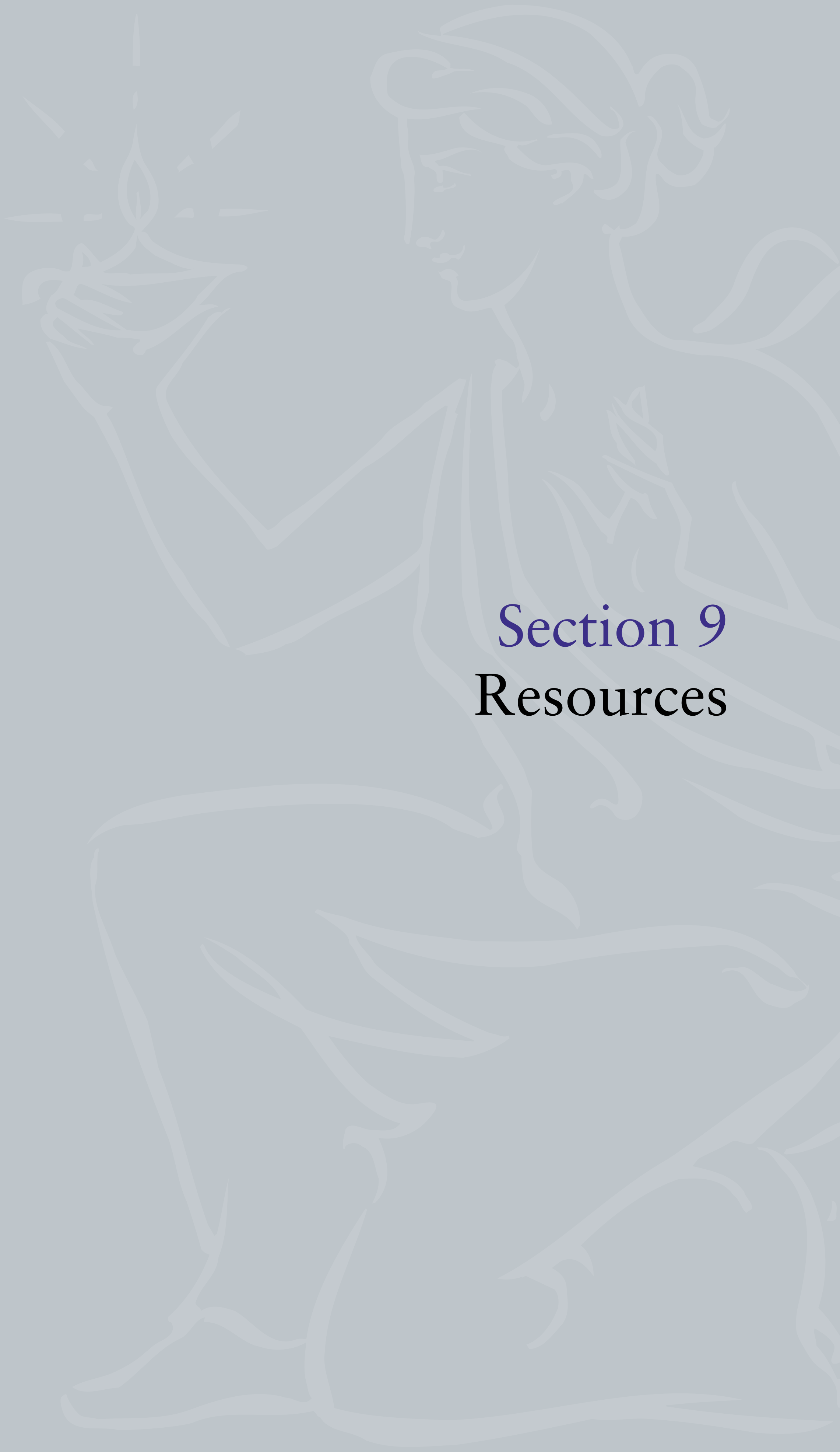
FITNESS TO STUDY

Each training programme, or rather the university hosting the programme, will also have Fitness to Study procedures in place. These can be called upon, ideally as a last resort, when a course deems a student unfit to engage with their studies at a given time but the student is unable or unwilling of their own accord to seek an interruption to their studies. The general principle applies that it is preferable by far to raise and address concerns early and wherever possible put support or adjustments in place, rather than reach a point where formal procedures are called upon. In terms of mental health, instances when Fitness to Study procedures may be evoked include those where a trainee's behaviour, attendance record, or academic performance do not meet a minimum standard and this is believed to be the result of a physical and/or mental health problem, or where the student's behaviour presents a serious and immediate risk to self or others and/or the University's reputation. Fitness to Study procedures can vary widely across institutions and have a range of outcomes: hence, we advise readers to consult local policies.

Should trainees feel that they need support or advice around these issues, they should have access to support and advocacy via their local student union or other Unions.

09

SECTION



Section 9

Resources

RESOURCES

Resources designed to support someone in weighing up whether to share their lived experience with others and how to go about this are detailed in Section 5. Other useful resources are listed below:

ACAS

BPS Ethics Committee: Supplementary guidance on the use of social media

Hughes, G. & Spanner, L. (2019). The University Mental Health Charter. Leeds: Student Minds.

Mindful Employer

NHS Employers website's health and wellbeing section

NHS Workforce Health and Wellbeing Framework

NICE Quality Standard (2017). Healthy Workplaces: Improving employee mental and physical health and wellbeing.

Randall, J. (2019). *Surviving clinical psychology: Navigating personal, professional and political selves on the journey to qualification.* London: Routledge

Student Minds

Time to Change

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Lovell, J. (2017). *Self-disclosure in mental health services* (unpublished PhD thesis). York: University of York.

Meltzer, H., Griffiths, C., Brock, A., Rooney, C., & Jenkins, R. (2008). Patterns of suicide by occupation in England and Wales: 2001–2005. *British Journal of Psychiatry, 19*3(1), 73–76.

Mental Health Foundation (2016). *Fundamental facts about mental health*. London: Author.

Rao, A. & Clarke, J. in discussion with Hacker Hughes, J. and Kinderman, P. (2016). Wellbeing issues facing psychological professionals. *The Psychologist.* Leicester: The British Psychological Society.

Stevenson & Farmer (2017). *Thriving at work. The Stevenson / Farmer review of mental health and employers*. London: Department for Work and Pensions and Department of Health and Social Care.

Tay, S., Alcock, K. & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology, 74,* 1545–1555.

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Division of Clinical Psychology

MINORITIES IN CLINICAL PSYCHOLOGY SUBCOMMITTEE

@MinoritiesGroup

✉ minorities.cp@gmail.com

Minorities in Clinical Psychology Group

https://medium.com/@minorities.cp

https://bmesupport.typeform.com/to/flxpnA

Division of Clinical Psychology London Branch

UCL

SEEING IS BELIEVING: THE CHANGING FACE OF CLINICAL PSYCHOLOGY

https://www.youtube.com/channel/UCaXekgUmYema-0huj5iUcYA

COLLECTIVE FOR ASIAN PSYCHOLOGICAL THERAPISTS

Website: https://casianpt.carrd.co/

✉ casianpt@gmail.com

@CAsianPT

@casianpt

Collective for Asian Psychological Therapists

Collective for Asian Psychological Therapists

BAATN

Website: https://www.baatn.org.uk/

✉ administrator@baatn.org.uk

@baatnman

The Black, African and Asian Therapy Network

@BAATN

BLACK CLINICAL PSYCHOLOGY NETWORK (BCPN)

✉ blackcpnetwork@gmail.com

BiPP NETWORK

Website: https://www.bippnetwork.org.uk/

@BIPPNetwork

@bippnetwork

Black and Minority Ethnics in Psychology & Psychiatry Network

BIPP Network

NORTH THAMES INDEPENDENT PERSONAL ADVISOR (IPA) SCHEME:
"BAME" TRAINEE STRAND

Section 32 of UCL DClinPsy Training Handbook

✉ Leah Markwick l.markwick@ucl.ac.uk to access the IPA list. Once an IPA has been chosen, please let Leah know immediately to ensure that the list of available advisors is updated

RACISM ON THE COUCH

Website: https://www.racismonthecouch.com/

@racismonthecouch

UK DOCTORATE IN CLINICAL PSYCHOLOGY (DCLINPSY) INTERNATIONAL COMMUNITY

Website: https://www.dclinpsy-international.co.uk/

SOUTH ASIAN MALE THERAPISTS' SPACE (CURRENTLY IN DEVELOPMENT)

✉ Dr Shah Alam: shah.alam.2018@live.rhul.ac.uk

SECTION 34 APPENDIX 1: COURSE POLICY ON PERSONAL AND PROFESSIONAL DEVELOPMENT

Introduction
Because the Course places a strong emphasis on the development of a wide range of clinical and academic skills, and it can be easy to lose sight of the fact that clinical training should be a time of personal and professional development, and that training can be a stressful experience. On this basis Course policy, and more importantly Course practice, is oriented towards creating conditions that support personal development, and offering support systems designed to ameliorate stress.

To be more specific, the Course values the development of personal skills which are rooted in self-awareness in relation to feelings and values, such as a capacity to reflect on one's practice, an ability non-defensively to recognise one's limitations, an openness to new learning, and a sense of how personal feelings can be legitimately incorporated into professional life. It also considers a capacity to care for oneself a critical part of practice, since balancing personal needs against work demands can be difficult to achieve. These are valuable skills in their own right, but there is some consensus that practitioners with these capacities are more likely to engage well with their clients and colleagues, and hence work more effectively and productively.

The Course attempts to foster a climate in which personal development is seen as a legitimate part of professional training. This is especially important given that at times the demands placed on trainees are considerable, and that to some extent an experience of personal stress is normative. Trainees need to know that the Course takes this perspective, and to feel able to seek support without feeling that this will be counted against them.

The Course follows a number of principles in order to actualise these aims.

Course structures and procedures
The Course aims to ensure that it operates in a way that reduces unnecessary stress by minimising uncertainty and maximising the clarity and transparency of its procedures.

a) Trainees should be clear about the expectations of the course in relation to academic, clinical and research standards.
b) Trainees should be fully informed about course structures, such as the various tutoring and support systems available to them
c) Trainees should understand the roles of individual members of course staff
d) Course staff should be aware of their roles and responsibilities in relation to trainees, and make it as easy as possible for trainees to access support associated with their roles.

In practice the Course should:

a) ensure that trainees have regular scheduled access to their Course Tutor, with the aim of maintaining contact and facilitating development
b) ensure that there is easy access to clear written information about every aspect of its functioning, available in hard copy through the Trainee Handbook, the Supervisors' Handbook, the Staff Handbook, and also available on the Unit webpage.
c) endeavour to maintain clear channels of communication through it various committee structures, enabling trainee feedback to be heard, and acting on that feedback as appropriate, and particularly when it becomes clear that poor communication or organisation is creating difficulties for trainees.

d) ensure that trainees are given appropriate professional supervision and support related to the various aspects of the programme they are undertaking (academic, clinical and research)
e) have in place feedback and auditing systems to monitor the efficacy of its support systems, and ensure that action is taken when it becomes clear that supervision or support is not adequate or is failing.

Personal and professional development in the teaching programme
The Course aims to structure the teaching programme in a manner that fosters an openness to learning and development. It should include teaching regarding the various support systems, on the management of stress, and schedule sessions that enable discussion of the various personal transitions inherent to training. It should also include sessions which enable the year cohort as a whole to reflect on its development and progress through training.

Course Tutoring systems and systems for Developmental Review
The Course aims to put in place tutoring systems that are genuinely facilitative rather than simply reactive to problems. This is critical, because this stance is one of the most fundamental ways in which the Course can represent its commitment to trainee development, and make this process come alive for the trainee. In practice this means that meetings with tutors should take place on a regular basis, and include discussion of strengths and achievements rather than being focused only on areas of concern.

At the start of the Course each trainee will be allocated a Course Tutor who meets with them at regular intervals throughout the Course. The purpose of these meetings is to ensure the development of a supportive relationship between individual trainees and a member of the Course Team.

Meetings will usually involve discussion of academic, clinical, professional or personal issues. Course Tutors will also undertake a more formal annual Developmental Review, which aims to clarify individual training objectives, provide feedback on performance, overview professional development, advise on career options and elicit feedback on the Course from the trainee.

Personal support systems
It is important that the course gives trainees ready access to systems of personal support in order to demonstrate that these are potentially integral to the process of training.

To achieve these aims it will ensure that trainees are fully informed about the various systems of support open to them. As one of the most readily available sources of formal support is the Student Counselling Service, representatives from this service will be invited to attend the trainee induction programme.

The Course recognises that under some circumstances it can be inappropriate for Course staff to act both as facilitators and appraisers. This can be the case when trainees are having significant difficulties on the Course, and the Course Tutor is involved in appraisal of failure. Although this is not invariably problematic, where it is clear that the trainee-Tutor relationship is under strain, the Course will usually assign trainees to an additional member of staff, usually on the basis of trainee choice, who can act to support the trainee. Trainees should be informed that such requests will not influence the appraisal process.

Because of the inevitable strains between appraisal and facilitation, the Course offers trainees support from Personal Advisors. These are qualified clinical psychologist with whom the trainee meets to discuss personal and professional issues arising out of training, but in confidence and outside of the Course. Personal Advisors will be people who usually are not directly associated with the supervision or evaluation of the trainee. The scheme is intended to enable personal and professional development throughout training rather than being used for crisis management or personal therapy.

The Course recognises that it may be particularly useful and important for black and ethnic minority trainees and for gay and lesbian trainees to have mentors who can help them to integrate their personal with their professional experiences. On this basis the Course offers a parallel Personal Advisor scheme oriented towards these two groups.

Physical Disability and Mental Health Problems

The Course recognises that trainees with physical disability and mental health problems may experience additional levels of stress. The Course will take responsibility for making appropriate adaptations that enable trainees to undertake and complete the Course. It will do this by consultation with the trainee regarding their needs, liaison with the UCL Disability Service and with the Occupational Health Service of the trainee's employing NHS Trust.

The Course recognises that disability comes in many forms, and that not all disability is immediately apparent. It also acknowledges that individuals with disability are keen for this not to be the characteristic by which they are defined, and that a failure proactively to make appropriate adaptations can – inappropriately - make their disability the focus of attention. On this basis the Course and especially Course Tutors will signal their willingness to discuss such matters, and to demonstrate a willingness to be responsive to need. It is often clinical placements that present the greatest challenge to adaptation for individuals with disabilities. On this basis the course will:

- a) represent its concern by explicitly asking trainees about their needs (for example in pre-placement allocation questionnaires)
- b) make it clear that in order to meet these needs, individuals will be privileged over their peers in placement allocation

Physical Illness

The Course recognises its responsibility to trainees who suffer significant physical illness while on the Course. While medical advice and prognosis are obviously important, the Course will take all steps to ensure that on recovery trainees are offered appropriate additional support in order to help them complete their studies.

Trainees who act as carers

Trainees with significant duties as parents or as carers may, at times, find that these impose restrictions on their capacity to undertake aspects of the Course. The Course will be responsive to these concerns, and it is part of the Course Tutor role to discuss appropriate accommodations (for example, to course deadlines or to placement allocations) where it is clear that these are required.

Information about how these various principles are realised in practice can be found in the Trainee Handbook and the Supervisors' Handbook, which contain information about personal and professional support systems. Details of sessions offered by the Course as part of the teaching programme can be found on the Course website (http://www.ucl.ac.uk/dclinpsy/).