# University of Leeds – Clinical Psychology Training Programme

## Development of Specific Therapy Competencies During Clinical Training – Guidance for Supervisors

BACKGROUND

The BPS Standards for Doctoral Programmes in Clinical Psychology have always stated that training had to include development of competence in therapeutic models, but since 2014 we have had to evidence trainees’ competence. Trainees need to evidence their competence in CBT and one other model by the end of the three years of training.

Some courses have chosen to offer just two models of therapy throughout training. Following consultation with trainees and the recognition that the majority of our supervisors locally practice using a variety of therapeutic frameworks, it was agreed that the Leeds Programme would continue to offer teaching and training in a number of different models. For example:

* CBT
* CAT
* Systemic
* Third Wave approaches (CFT, ACT)
* Psychodynamic / ISTDP
* Neuropsychology

The criteria we are using to assess therapeutic competence are primarily adapted from the work by Roth and Pilling (e.g. 2008) and tailored locally by supervisors with specific interest / expertise within these frameworks. The Neuropsychology competencies have been developed by local neuropsychologists in line with national frameworks.

We recognise that trainees may have specific placements with supervisors who focus on models they are interested in, so they may chose to complete that model’s competency framework on that placement.

The biggest implication of this for supervisors, is in supporting trainees to develop and evidence competencies in these specific models of therapy. Using the competence frameworks provided and your own specific model/s of choice, we ask that you discuss / observe / record and finally agree that the trainee has demonstrated competence in their therapeutic skills in relation to the competency frameworks.

Trainees will continue to get experience in a variety of other models but they **do not need to evidence all of these unless they choose to**. The requirement is **CBT plus one other model of therapy**.

The following questions and answers are intended to inform your thinking around the above. Please do not hesitate to contact any of the Clinical Tutor team if you have any queries or questions in relation to this. Thank you for your consideration and support.

Competency Development

For competency development to be signed off by supervisors each has to be discussed in supervision, observed and competently applied. However, for therapy competencies all observations are *by* the supervisor *of* the trainee. For neuropsychology competencies this is different; the trainee needs to *observe the supervisor* in the first instance. These differences are outlined below and on PebblePad:

Therapy Competencies

Please note that all of the ratings of competencies should be discussed between supervisor and trainee with the final assessment being the responsibility of the supervisor.
**Brief Definitions of Ratings:**
**Discussed in Supervision**- This skill has been discussed in some depth in supervision
**Observed**- The supervisor has observed this skill being demonstrated by the trainee **Competently Applied**- This skill has been applied competently\* in the trainees' clinical practice (\*as defined by the supervisor).
**Reflections-**The trainee notes key reflections about their learning here.

Neuropsychology assessment

Please note that all of the ratings of competencies should be discussed  between supervisor and trainee with the final assessment being the  responsibility of the supervisor.
**Brief Definitions of Ratings:**
**Discussed in Supervision**- This skill has been discussed in some depth in supervision
**Observed**- The trainee has observed this skills being demonstrated by another clinician
**Practiced**- This skill has been used in clinical practice by the trainee
**Competently Applied**- This skill has been applied competently\* in the trainees' clinical practice (\*as defined by the supervisor)
**Evidence/Reflections** (see box at the bottom of the page)- If possible, please indicate where evidence of this may be found e.g. PAF, observation by supervisor, supervision notes.

Please find a link to a form here to support you in making assessment of your trainees’ neuropsychology competencies.

Please note: ***ideally all observations, practice and sign off as ‘competently applied’ will occur in clinical practice. However, it is recognised that on occasion there may be limited opportunity to complete this in this context. Therefore, it is possible that this can occur using role play in supervision if deemed appropriate by the supervisor. Please do discuss with any member of the clinical tutor team if you have any further questions.***

Frequently Asked Questions

* Are trainees expected to be have completed all competencies for one model after one placement?

**No. We anticipate that the competency development will occur over the three years of training.**

* Would you be expected sign off competencies within a model with which you’re not familiar?

**There is no expectation that you will sign off any competencies within a model you are not familiar with.**

* Will the course have to match trainees’ preference for their ‘+1’ model with specific supervisors / placements?

**This is likely to become a consideration and is something that we will be monitoring.**

* What is the benchmark and how is progress tracked? E.g. difference between a first year and a third year?

**We are aiming for the development of as many competencies as possible within CBT and a +1 model across the 3 years, rather than expecting a developmental trajectory. For example, some people may get to 2nd year with no CBT experience so it would be unfair to expect them to be showing any advanced levels in 3rd year.**

* Do trainees have to 'formally' engage a client in a therapeutic approach e.g. Compassion Focused Therapy (CFT) to be considered competent? Or is it that they might display a variety of competencies from various modalities with each client and fill in the spreadsheet as and when?

**Whilst we would encourage trainees to gain experience within a particular therapeutic approach when possible we recognise it can be both:**

* **You may chose to focus on the development of competencies within a specific model dependent on the models you draw on a supervisor eg. solely CBT**
* **Alternatively, you may choose to discuss, review and evidence with your trainees the models they are drawing on within their practice, and identify which competencies you feel are achieved within a particular model, and document them after discussion.**

**Eg. a trainee may have demonstrated competence in ‘understanding a problem from a systemic perspective’ (Systemic Therapy) and ‘agreed and collaboratively set agenda for session content and structure’ (CBT)**

* Do you have to have further specialist therapy training prior to signing off competencies?

***There is no expectation that supervisors have had specialist training in a model to enable them to complete the logbook.* Trainees’ may seek out 3rd year placements with supervisors who have completed further specialist training.**

* Does it devalue integrative therapies / ways of working / supervisors?

**No - but what it does recognise is what particular aspects of particular theoretical models you are integrating.**

* Do you need to have observed / listened to the trainee directly or is self-report enough?
* How many times do you need to have observed?
* How do you evidence the competencies? / Who fills it in?

**Our expectation is that the trainees will complete the log after discussion with you in supervision, following observations / review of audio / video recordings. The logbook will be discussed at placement meetings. We are encouraging observation of trainees in different forms as we have always done, but not asking for a specific number of times – rather that you use your clinical judgement as to whether you feel the trainee has demonstrated a particular level of competence (ie. discussed in supervision / been observed / demonstrated competence).**

* Can other team members or just the supervisor assess competency? E.g. colleagues experienced in psychodynamic therapy if the supervisor is not skilled in this area?

**Yes, to demonstrate competency development we can draw on other therapists’ skills.**

* Are trainees expected to give examples of competencies to aid learning for future placements?

**Previous placement experiences are discussed when contracting at the beginning of placements. It would be useful if discussion / examples of competency development on previous placements forms part of this discussion.**

* How are experiences weighted? Common factors vs therapy skills? How to maintain emphasis on common factors?

**We are training clinical psychologists, not therapists in a specific model and as such will endeavour not to lose our emphasis on the generic therapy skills. Our Clinical Observation form is attached with this email as an optional way of facilitating discussion with your trainees about the development of generic therapy skills within the framework. It could be helpful for your trainees to observe you whilst using the form and then discussed, or vice versa.**

* To what extent is the supervisor expected to ‘bend’ the placement to fit in with the competencies and what the trainee expects to achieve for that placement? E.g. setting up opportunities for trainees to co-work with other professionals?

**At this stage we are not asking for you to change what is offered on placement. Rather it is a shift in thinking about the development of specific therapy competencies within the experiences that would be gained on placement and how to evidence this ie. through observation, review of audio / video-recordings.**

* Can the course support departments to have access to technology to support audio / video recordings?

**No. There are governance issues that would need to be considered for each Trust that would unfortunately mean this is not possible.**

* Do we use the clinical observation form as a framework to assess generic therapy skills? And use PAF to make general therapy skills observations?

**We would encourage that the PAF is used as it always has been – in the development of competencies within the competency framework. As discussed above, the clinical observation form is an ‘optional extra’ for you to use with your trainee as you feel it is helpful. We would encourage the use of it at least once on the first placement.**

* How do you record competencies that don’t fit under these models? E.g. behavioural work in LD

**Trainees could choose to log these in different ways eg. the PAF, reflective learning notes etc. We continue to want to see a broad range of competency development across the three years of training that is not restricted to specific therapy competencies.**

* Will it be constraining for trainees eg. feeling they have to put certain elements into sessions so that they can tick them off?

**This is a possibility but will be an area to be monitored.**

* How are trainee’s’ expectations managed by the course? E.g.

- You won’t get all the competencies in one placement;

- You won’t become a family therapist in one placement

- Will trainees feel they need to have ‘purist’ supervisors?

REFERENCES

Roth, A. D. and Pilling S. (2008). Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behaviour therapy for depression and anxiety disorders, Behaviour and Cognitive Psychotherapy, Vol. 36 (02), p. 129-147.

Standards for the Accreditation of Doctoral Programmes in Clinical Psychology, January 2019. The British Psychological Society: Partnership and Accreditation.