UNIVERSITY OF EXETER

CEDAR
Clinical Education Development and Research

PG Diploma in Psychological Therapies Practice (Children, Young People & Families)

Programme Handbook

CYP IAPT 12

2024 - 2025

www.exeter.ac.uk/cedar

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Welcome

Welcome to the University of Exeter's Postgraduate/Graduate Diploma programme in Evidence-Based Psychological Therapies for Children and Young People. This programme is part of the national Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) initiative and has a Cognitive Behavioural Therapy (CBT), Parenting (PT), 0-5, Systemic Family Practice (SFP) and ASD/LD pathway.

The overall aims of the CYP IAPT Programme are to transform mental health services for young people and their families/carers; to maximise their effectiveness and efficiency and thus improve access to evidence-based and outcome-monitored interventions.

The programme is heavily rooted within the development of clinical skills associated with a patient-centred approach and on the skills required to support CBT, PT, 0-5, ASD/LD and SFP evidence based therapies.

The continued development of these skills is embedded within a strong focus on practice-based supervision, which is a fundamental component of the training. As such your training should not just be seen as being the time you spend being taught within the University, but full time, based also around your clinical work undertaken within your work setting supplemented by your practice based supervision.

Successful completion of clinical and written assignments and appropriate participation in tutorials and workshops will lead to the awarding of a PG/Grad Diploma. We hope that you will be able to act as 'product champions' for CBT, parenting, 0-5s, ASD/LD and systemic practice and to be available as teachers and consultants, in the various CYP IAPT settings in which you work.

A major contributing resource to the programme is the knowledge and experiences that you as programme members bring. We intend to draw upon and honour this knowledge and experience in order to develop clinical skills and increase awareness and theoretical understanding. It is important, however, that understanding and use of theory is integrated with clinical application in a rigorous and constructively critical manner.

We hope you enjoy the training and look forward to meeting you over the coming months.

Dr Alex Boyd, Co-Director of CYP Programmes

Meet the Team

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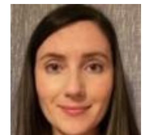

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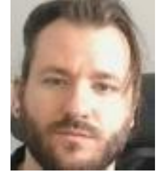

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Introduction and Aims

In this Programme we aim to help you develop your practice in evidence-based psychological therapies for children, young people and families.

You will develop the knowledge and competencies required to be an effective practitioner, as determined by the relevant national curriculum for the CYP IAPT Programme.

We aim to provide you with a high quality and stimulating learning experience in a supportive environment that is enriched by an internationally recognised research environment, nationally recognised innovative clinical teaching approaches and current clinical practice.

The programme aims to ensure that all graduates meet recognised minimum clinical competence in working using CBT with young people with affective disorders.

Specific Programme Aims

On completion of the programme we hope that you will be able to:

- Demonstrate generic and modality-specific skill competencies in evidence based psychological therapy as determined by the CYP IAPT national curriculum.
- Synthesise the key underpinning knowledge in evidence based psychological therapies for children, young people and families.
- Critique the context within which psychological therapies are provided (including relevant professional, ethical and legal frameworks).
- Explain in detail the key theoretical bases for evidence-based psychological therapy models and link their relationship to practice and understand, interpret, critically evaluate, and apply evidence-based practice.
- Evidence appropriate use of supervision in developing clinical skills.
- Analyse and manage the implications of ethical dilemmas and work proactively with others to formulate solutions and manage complexity.
- Function independently and reflectively as a learner and practitioner.

It is our intention that trainees from all diverse backgrounds and perspectives be well served by this course, that trainee's learning needs be addressed both in and out of teaching sessions, and that the diversity that trainees bring to this cohort be viewed as a resource, strength and benefit. It is our intention to present materials and activities that are respectful of diversity: gender and gender identify, sexuality, disability, age, socioeconomic status, ethnicity, race, and culture. Your suggestions are invited, encouraged and appreciated. Please let us know ways to improve the effectiveness of the course for you personally or for other trainees or student groups. In addition, if any of our training sessions conflict with your religious events, or if you have a disability or other condition necessitating accommodation, please let us know so that we can make the necessary arrangements for you.

Our goal as a learning community is to create a safe environment that fosters open and honest dialogue. We are all expected to contribute to creating a respectful, welcoming, and inclusive environment. To this end, classroom discussions should always be conducted in a way that shows respect and dignity to all members of the class. Moreover, disagreements should be pursued without personal attack and aggression, and instead, should be handled

with grace and care. This will allow for rigorous intellectual engagement and a deeper learning experience for all.

(Statements adapted from the University of Iowa, College of Education and Yale University – Dr Carolyn Roberts, Assistant Professor, History of Science & History of Medicine, and African American Studies)

CBT Programme Structure

There are two modules within the CBT pathway. The core module and CBT module both worth 60 credits. For information about the core module, please see the core module handbook.

Code	Title	Credits
PYCM027	**Core Skills for Working with Young People with Mental Health Problems and Their Families**	60
PYCM028	**Evidence Based CBT for Children and Young People** In this module you will develop your practice in evidence-based psychological therapies for children, young people and families. You will develop the knowledge and core competencies required to be an effective CBT practitioner, as determined by the relevant national curriculum for the CYP IAPT Programme (such as CBT for Emotional Disorders).	60

General Administrative Information

University of Exeter Services

The University Campus

Find out more about the Streatham campus.

Key buildings you may wish to access include:

- The Forum (for Student Information Desk, non-academic enquiries & the Library)
- Devonshire House (cafés, shops, SU bar etc.)
- Reed Hall Mews (Student Health Centre).
- Northcote House houses the University's administration (the Vice-Chancellor, Registrar and Academic Secretary have their offices there, plus the Faculties Office, Registry, Accommodation and Examinations).
- The Sports Hall & open-air swimming pool adjacent to Cornwall House (open end of May to middle of September) and an indoor pool at St Luke's College.

Find out more information about parking on campus.

Student Information Desk

The Student Information desk is based in the Forum. Opening times are detailed here. To log an enquiry, click here.

The SID desk will routinely deal with most enquiries, including those to do with IT.

Library Facilities

The main library facilities are at the University of Exeter Streatham Campus. The library is stocked with psychology texts. The library catalogue, including access to electronic journals, and facilities for reserving and renewing books are on the web www.exeter.ac.uk/library.

Access to External Libraries

The SCONUL Access scheme is a UK based method to allow students access to other HE Libraries. It is a co-operative venture between most of the higher education libraries of the UK and Ireland.

It is available to:

- Academic staff on open or fixed term contracts

- Postgraduate research students registered for a PhD, MPhil or similar qualification
- Part-time, distance learning and placement students
- Full-time postgraduates

SCONUL Access also provides for a reference only service for full-time undergraduate students. These students are NOT entitled to borrow from other Libraries under the SCONUL Access scheme. More information can be found on the University Library website at www.exeter.ac.uk/library.

Study Skills Service

The Study Skills Service offers confidential help to any student who would like to improve their study skills. The Study Skills Advisors can help with the following:

- Reading effectively
- Selecting reading from book lists
- Planning and writing assignments or essays
- Taking useful notes
- Revising for exams
- Organising your time
- Generally evaluating your study skills

This service is available to postgraduates, who can and do consult the Study Skills Advisors. Help is available throughout each term and during part of each vacation - see www.exeter.ac.uk/student-engagement-skills.

The Wellbeing Service

More information regarding services provided by Wellbeing can be found here.

Students with Disabilities

The University employs Disability Advisors who offer support to students with disabilities and endeavours to provide facilities and equipment suited to people's individual needs www.exeter.ac.uk/accessability.

Education Enhancement

Education Enhancement provides professional guidance and support for students and academic staff in four related areas.

e-Learning Development promotes and supports the use of technologies in learning, teaching and assessment.

Academic Development offers professional and research informed advice and guidance to academic staff on aspects of learning, teaching and assessment in Higher Education. This unit is responsible for professional development programmes including LTHE (Learning and Teaching in Higher Education).

Academic Skills Development enhances student learning through workshops, lectures, individual appointments and innovative online materials.

Protection of Dignity at Work and Study

The University of Exeter is committed to a policy of equality of opportunity and aims to provide a working and learning environment, which is free from unfair discrimination and will enable staff and students to fulfil their personal potential. All individuals should be treated with dignity and respect whether at work or study: staff and students have an important role to play in creating an environment where harassment is unacceptable.

The purpose of this policy is to assist in developing a working and learning environment and culture in which harassment is known to be unacceptable and where individuals have the confidence to deal with harassment without fear of ridicule or reprisals. The policy aims to ensure that if harassment or bullying does occur, adequate procedures are readily available to deal with the problem and prevent it reoccurring. Harassment can have a detrimental effect upon the health, confidence, morale, learning and performance of those affected by it. A list of current advisors can be found on the above link.

The policies can be found at on the HR website.

Sexual Harassment

The University defines sexual harassment as 'attention of a sexual nature which is offensive or unwanted'. There is a leaflet available on the nature of the problem and how to deal with it. A copy is available on each of the year's notice boards and a further copy can be obtained from Reception. If you feel that you have experienced sexual harassment then read this document and discuss the matter with any of the University's trained advisors or with any member of Psychology. This service is confidential and further action is taken only with the knowledge and permission of the programme member.

It is worth pointing out that the University's policy on protection from sexual harassment extends to its staff as well as programme members.

CEDAR General Information

Access to Buildings

Washington Singer Laboratories and the adjacent Sir Henry Wellcome Building are home to the CEDAR programmes. Washington Singer Laboratories:

- Reception opening hours are 8am - 5pm term time.
- Building opening hours are 8am – 7.30pm.

If you wish to access the building out of hours please contact your Programme Administrator for advice.

Contact Details

Programme members are responsible for keeping their contact details and home address up to date. Any changes should be made via the MyExeter portal and the Student Record tab, and programme members should also make sure that their Programme Administrator is kept informed of any changes.

IT Facilities

There are numerous PCs with scanning and printing facilities available for programme members' use within Psychology.

In addition, all the PCs in rooms 220 and 221 are available for programme members' use in conjunction with undergraduates in Psychology. In term time these computers are subject to heavy use, although in University holidays they are underused. Software for PCs is available from the Psychology IT Department.

The University has many additional IT facilities. Please see the following links for more information:

- Openaccess
- IT Helpdesk

Programme Governance

Staff Student Liaison Committee Meetings

Programme members are able to participate in the running of the programme through participation in Staff-Student Liaison Committee meetings. These will be held once per term where the programme team will meet with the trainee representatives and for some SSLC committee meetings, Lived Experience Group members to discuss general issues in programme delivery.

SSLC meetings will consider any changes made to programme delivery dependent upon previous module evaluations. The Programme Lead will report to the Director of Clinical Training or Director of Programmes within the College of Life and Environmental Sciences.

Attendance and Absences

As explained in the individual strand handbooks, this course is a clinically- applied training and as a result, the aim is for 100% attendance. If any teaching is missed, you need to evidence with your course team how you have made up the learning and developed the competencies.

Your programme teams will monitor attendance closely with you throughout your training. Please make sure you sign the register on arrival to ensure that your attendance is recorded correctly. In the case you miss any of the teaching days (both within and outside of the university) through ill health **it is your responsibility to inform your employer (e.g. your line manager), the programme administrator and the relevant members of the academic team (e.g. the person who is teaching on that day and your personal tutor).** Please note that student absences can affect the quality of the learning experiences of the course. As such we do not expect you to take holidays when teaching has been scheduled. Should exceptional circumstances for leave arise then any requests for absence must be made in writing to the Programme Leads and agreed prior to leave being taken.

Maximum Duration Permitted for Completion of IAPT Training

Extenuating circumstances, mitigations, and situations in the workplace may on occasion require a trainee to request an extension to the completion date of their assessed work. Wherever possible, we will work with your Workplace Supervisor to devise a realistic time-scale for completion of the programme. However, as this is a one year programme and the University allows interruption of studies for up to a maximum of one year it is expected that all trainees will complete within 3 years.
Please see the University TQA manual for guidelines on interruptions and withdrawal from studies.

For further information about Programme Governance, please see the Generic IAPT course handbook

Marking, Assessment and Progression

Notched Marking Guidelines
With effect from the 2016/7 academic session, the CLES Education Strategy Group has agreed to implement a notched marking scheme to support consistency and reliability within the assessment process. Within the marking scheme only certain marks may be used within each grade.

Submitting Your Work
All written assessments should be word-processed using double-line spacing, font size of 11pt or 12 pt and in a font that is easy to read, e.g. Arial, Verdana, Tahoma. All pages should be numbered. To assist with "blind marking" please do not put your name or ID number anywhere in your submission.
Written work must stay within the specified word count and there will not be an upper percentage margin. Markers will stop marking at the point where the limit has been reached.
All work must be submitted by 1.00pm on the submission date.

It is your responsibility as a student to ensure that all work arrives by the submission deadline and that the version you submit is complete. For example, submitting a Case Report without the reference list would automatically result in the work failing.

Citing and Referencing
Psychology has adopted the American Psychological Association (APA) conventions as the standard for citations and references. As such references must be completed in APA style. It is important that programme members are familiar with the precise details of citing and referencing. We use the standard of 'a publishable article' and we expect citations and references to adhere to that standard. The information given here is based on the latest

edition of the Publication Manual of the APA. We would encourage you to consult these guidelines and copies are kept in the library, or can be obtained online at www.apastyle.org. There are many web sites providing summaries of the APA Style Guide (a Google search will identify these).

Please see this link for information about the Postgraduate Assessment scheme used within CEDAR.

Word Count Guidance

Please note that any words over the word count will not be marked.

The following content is NOT included in a final word count:

- Abstract
- Title
- Contents page
- Reference list
- Bibliography
- Footnotes (these should be used for references only; those containing large amounts of text will be treated as if they were part of the main body of text). Footnotes should only be used where directed by the module convenor.
- Appendices
- Words used in tables, graphs and other forms of data presentation (including titles of figures)
- Equations

The following content IS included in a final word count:

- Main body of text
- In text quotations
- In text references
- Section headings
- Footnotes containing large amounts of text (unless indicated otherwise by module convenor)

NB: Any tables or figures should be used judiciously to supplement and support the main body of the text for the assignment being submitted. Where tables and figures stand alone and are not referred to within the text, these will not be included within the marking and this can lead to assignments being failed. Reports or essays should make sense and be capable of being read without the tables or figures. If you have any doubts about this, please seek the advice of your tutor or a member of the academic team BEFORE making a submission.

Re-assessment Procedures

Referral: A referral is a further attempt permitted by the examiners, following initial failure of an individual module, or the assessment(s) or examination(s) for that module. There is no requirement to repeat attendance. The module mark following a referral is capped at the pass mark of 50% (postgraduate). For any assessment, candidates have a right to be referred on one occasion only. Where the Board of Examiners decides there are adequate grounds, such as medical reasons or exceptional personal circumstances, it may allow a deferral (i.e., re-assessment without the mark being capped), or permit a further referral.

In the event of any piece of work being referred it will be returned to the programme member with instructions from the programme administrator for its resubmission. Please do be aware that a failure on any assignment in a module results in the **whole module** being capped at 50%, regardless of what marks subsequent assignments in that module may achieve.

Marking and Appeals Procedure

If a student feels that there has been irregularity in the marking of an assignment and wishes to appeal against a provisional mark prior to the Examination Board, they should bring the grounds for their appeal in writing promptly to the attention of the Director of Clinical Training, who may then seek the opinion of an additional marker. The External Examiner would then review both marks and the correspondence. This will usually resolve the matter, but if a student still feels that he or she has grounds for a formal appeal, the university's procedures for doing this can be found in the TQA manual. Marks are regarded as provisional until ratified by the APAC (see below).

Student Complaints Procedure

Information about the University Student Complaint Procedure can be found here.

Academic Probity

The definition of cheating and plagiarism in this document are taken from the University's Teaching Quality Assurance (TQA).

Definitions and offences are outlined in the TQA here. Information on poor academic practice and academic misconduct is also outlined in detail here.

Assessment, Progression and Awarding Committees (APACs)

A Board of Examiners will meet at the end of each programme to recommend awards. The Board comprises the Programme Lead and the External Examiner(s). It is chaired by the Director of Clinical Training, in accordance with University procedures.

Results of students who have successfully completed the programme will be sent for ratification at the Vice Chancellor's Executive Group meeting. Results of students who are unsuccessful will be considered at a Consequences of Failure Board. This Board will make recommendations for the consequences of failure for individual students. These

recommendations will be approved (or otherwise) by the College Associate Dean for Education, who will submit recommendations to the Dean of Faculty for final approval. On occasions the information contained within this programme handbook regarding programme governance and assessment may be different to that agreed at the wider college and university level. Such differences are due to the specific training and educational requirements encountered with programmes, in particular those required as part of the professional body accreditation process, the delivery of national curriculums and requirements of the SHA tender processes. Where there are differences, information contained within this programme handbook should take precedence.

It should be noted that you will not officially complete the programme until your award has been approved at this Board and approved by the Vice Chancellor's Executive Group.

Teaching

Each year we begin the course with a focus on the core teaching module. Some of this teaching is delivered for all strands as a whole cohort, whereas other core sessions are delivered individually in strands. The majority of your core teaching will be completed by the end of term 1. Core teaching days will be clearly indicated on the timetable.

Teaching in Terms 1 and 2 is held every week. You will have a whole day tutorial on Mondays, with Tuesday mornings focused on supervision and Tuesday afternoons on skills-based practice. In Term 3 teaching moves to alternate weeks.
Teaching is carried out with a combination of both on campus and remote delivery. Where teaching is online, this is delivered mostly as live tutorials, via video-conferencing. There is also some asynchronous content to our online delivery. All necessary links to online teaching will be embedded in your timetable.

Core Teaching Days 2024

Term 1

Week 1 – 9, 10, 11, 12 January 2024
Week 2 – 16, 17, 18 January 2024

training days = 38.5 hours (2024) (each taught day = 5.5 hours)

Total for year Core training hours = 38.5 hours (2024)

CBT Teaching Days 2024

Term 1

Week 1 – 8 Jan 2024
Week 2 – 16 Jan 2024
Week 3 – 22, 23 Jan 2024
Week 4 – 29, 30 Jan 2024
Week 5 – 5, 6 February 2024
Half Term
Week 6 – 19, 20 February 2024 – **KSA Tutorial 9-10am (20th Feb)**
Week 7 – 26, 27 February 2024
Week 8 – 4, 5 March 2024
Week 9 – 11, 12 March 2024
Week 10 – 18, 19 March 2024 – **KSA Tutorial 9-10am (19th March)**
Week 11 – 25, 26 March 2024

training days = 107.25 hours (2024) (each taught day = 5.5 hours)

Term 2: CBT (DATES TBC)

Week 1 – 15, 16 April 2024
Week 2 – 22,23 April 2024
Week 3 – 29, 30 April 2024
Week 4 – 7 May 2024
Week 5 – 13, 14 May 2024
Week 6 – 20, 21 May 2024

(Half-term)
Week 7 – 3, 4 June 2024
Week 8 – 10, 11 June 2024
Week 9 – 17, 18 June 2024
Week 10 – 24, 25 June 2024 – **KSA Tutorial 25th June (9-10am)**
Week 11 – 1, 2 July 2024
training days = 115.5 hours (2024) (each taught day = 5.5 hours)

Term 3: CBT (DATES TBC)
Week 1 – 9th, 10th Sept 2024
Week 2 – 16th, 17th, Sept 2024
Week 3 – 23rd, 24th Sept 2024
Week 4 – 30th Sept, 1st Oct 2024
Week 5 – 7th, 8th Oct 2024 - ***KSA Tutorial 8th October (9-10am)***
Week 6 – 14th, 15th Oct 2024
Week 7 – 21st, 22nd Oct 2024
(Half-term)
Week 8 – 4th, 5th, Nov 2024
Week 9 – 11th, 12th Nov 2024
Week 10 – 18th, 19th Nov 2024
Week 11 – 25th, 26th Nov 2024
training days = 77 hours (2024) (each taught day = 5.5 hours)

Total for year CBT training hours = 299.75 (2024)

Grand total for Core and CBT training hours = 341 hours (2024)

Please note that the minimum taught hours required to satisfy BABCP accreditation regulations is 300 hours. Any absences which take the total hours attended below 300, **MUST** be accounted for by using the University's "Missed Learning Activities" procedure detailed below under the section on attendance.

Please note also that the course is not formally completed until the successful submission of all examined work. The diploma is not awarded until the Academic Progress and Awards Committee (APAC) has met, normally in the Spring of the year following course completion.

Office Hours

You can contact the team by email for any queries you may have. Alternatively, approach the help-staff at Washington Singer Reception Desk and if they cannot assist you, they will consult with the dedicated course administration team.

Feedback

Students must complete electronic feedback via Qualtrics. You will receive emails with links to complete the feedback. You will also need to evidence that you have completed feedback as part of your Clinical Portfolio assessment. Feedback provides a vital opportunity for students to give their opinions and thoughts on teaching sessions and allows the CYP-IAPT team to implement new suggestions and changes for future cohorts.

Location of Teaching
Teaching and supervision takes place both on campus and remotely. Remote teaching sessions are carried out using Zoom and supervision takes place over Microsoft Teams, as this currently meets information governance requirements for most organisations. On campus teaching takes place usually in the Washington Singer Building at the University of Exeter. Other rooms on campus may be needed from time to time for teaching and supervision and these will be marked on your timetable. We recommend that you regularly check your university email as any last minute changes to teaching arrangements will be communicated using this email address. For remote teaching, a register will be taken by the lecturer to confirm attendance. When on campus, the lecturer will take a register.

Structure and Timings of University days

Below are the current structure and timings for teaching delivery.

Mondays

9:30am – 4:30pm Whole group CBT teaching/workshops

There will be a 15 minute break in the morning and afternoon sessions and a 1 hour lunch break.

Tuesdays

9.30 – 10.00 Preparation for supervision groups

10.00 – 12.30 CBT group supervision

12.30 – 1.30 Lunch

13.30 – 16.30 Whole group CBT clinical skills tutorials

Please refer to the Core handbook for Core Teaching timings, as these may differ

Study Time

Trainees are required by National Guidance to **have a minimum of 28 days study time** in addition to taught hours. We have timetabled in 6 days study time during half terms. It is recommended that the remaining 22 days are spread throughout the year, either as a half day each week or an arrangement that works best for the programme member and their employer.

Attendance / Missed Session Learning Activity

The PGDip CYP-IAPT PTP (CBT for CYP) requires a high level of attendance in order to meet both the university and the BABCP required standards for the award as noted in the handbook. However, we appreciate that unforeseen circumstances do arise that make it

difficult to attend occasional sessions. We therefore have provision to complete a Missed Session Learning Activity Record Form (see below). This does not apply to missed University supervision sessions. Neither does it apply to multiple missed sessions where programme suspension is likely.
Unfortunately we are unable to authorise annual leave during term time except in exceptional circumstances, should this be a concern then please discuss this with your tutor.

Download: Missed Session Learning Plan

A Missed Session Learning Activity plan requires completion for any given absence to be agreed with the lecturer for the missed teaching. Designing an appropriate missed session learning activity is the responsibility of the student but clear guidance is given here about how it should be done. The activity is based on the learning objectives from the missed session which are usually available from the session handout on ELE or from the lecturer. The learning outcomes must be recorded on the 'Missed Session Learning Activity Record'.

The missed session learning activity requires active and creative engagement with the material in order to address the learning deficit in your CBT skill development following the missed session. It is often useful to determine whether any other students have missed the session and complete the activity together, allowing peer discussion and deeper reflection on the material. Students may also utilise small group work with peers, who may or may not have missed the session, and are willing to participate in an additional learning exercise to supplement their own knowledge and skill development. This allows for the use of role play and enhances applied clinical skills as well as theoretical knowledge. Learning activities are likely to include reflection on two or three relevant texts and / or recorded material linked to the learning outcomes.

Your learning activity will take approximately the duration of time missed e.g. a six hour learning activity for a missed teaching day. Self-directed study can be a part of the missed learning activity, although some more active engagement with fellow students is also required. A required part of any plan therefore, is evidence of active learning with your peers or clinical supervisor, such as discussion, role play or similar.

The missed session learning activity *must be agreed with your Academic Tutor or lecturer prior to completion of the activity.* Your Academic Tutor is required to sign the plan twice – once to confirm agreement with the proposal, and once to confirm completion of the activity. If the initial signature is not sought, you may need to complete a further learning activity.

Accreditation

The British Association for Behavioural and Cognitive Psychotherapies (BABCP) is the current accreditation body for cognitive behavioural therapists. The Exeter University CYP-IAPT CBT course is accredited by the BABCP as a Level 2 Accredited Course. This is a big advantage when applying for provisional accreditation once the course has been completed. More detail about this will be provided as the course progresses. In the meantime, you are welcome to look at the BABCP's website, and to approach any of the course academic team with queries you may have regarding this. **All students are now required to register membership with the BABCP before starting their training course.**

Competencies

The University of Exeter CYP IAPT CBT Programme has been designed in line with the generic CAMHS competency Framework (Roth and Pilling, 2011 see page 15) and the CYP IAPT national curriculum. For the CBT pathway, the CBT Competencies Framework will also be drawn upon where appropriate (Roth & Pilling, 2007 see page 16).
For further information the CYP IAPT national curriculum, please download:
CYP IAPT Curriculum for ERG
For further information on CAMHS Competencies and CBT competencies please visit the UCL CORE page.

IAPT disorder specific models are those referred to within the CBT competencies framework – references for these models are available by accessing this framework online at the above link, and more specifically for children and young people by consulting the CYP-IAPT national curriculum document, hyper-linked as above.

Key Manuals / Papers for each Anxiety Disorder / Depression

CBT for Anxiety

The evidence base for CBT for children and young people with anxiety disorders refers to both anxiety disorders generally and to specific anxiety disorders.
There is guidance from NICE for GAD and panic disorder (CG 22, updated by CG113) which does not include children and adolescents. PTSD (CG 026), OCD and body dysmorphic disorder (CG 031) as well as Social Anxiety Disorder (CG159) have guidance which covers the age range including children and adolescences.
There is no further NICE guideline on the other anxiety disorders, as they present in childhood, young people, or in adults. The most substantial evidence base for CBT for GAD, separation anxiety and social phobia in children and young people comes from trials of the *Coping Cat* manual (Kendall & Hedtke, 2006) and related manuals.
There is an emerging evidence base from trials of CBT with children and young people with varied diagnoses of anxiety disorders. In addition, there are well-designed trials of CBT for specific anxiety disorders in children and adolescents not covered by NICE guidance to date. Within this complex and evolving evidence base, the curriculum is not prescriptive about which of the evidence based CBT competences, with their associated models, should be

taught. There is in any case, as would be expected, substantial overlap between the evidence based CBT approaches. Therefore the following will be covered within the CYP CBT strand.

PTSD NICE CG 26; Roth, Calder & Pilling (2011) Ehlers & Clark (adapted by Smith)

OCD NICE CG 31; Roth, Calder & Pilling (2011) March & Mulle (1998) & Salkovskis (1999) (adapted to CYP)

GAD (Kendall & Hedtke, 2006 a&b). For older adolescents, consult NICE CG 22 and CG 113 f or adults – Borkovec & Sharpless (2004), Dugas & Robichaud (2007).

Panic Disorder For older adolescents, consult NICE CG 22 and CG 113 for adults. Clark (1986, 1996). There is little evidence base for CBT for panic disorder in children and younger adolescents.

Social Phobia (Kendall & Hedtke, 2006 a&b); Clark (2005)

Separation Anxiety Disorder (Kendall & Hedtke, 2006 a&b): Schneider & Lavallee (2013).

Specific Phobia (Kendall & Hedtke, 2006 a&b). Kirk, J. & Rouf, R. (2004). Ost, L. G. (1989).

References:

Kendall (GAD, Social Anxiety, specific phobia)

Kendall, P. C., & Hedtke, K. A. (2006a). *Cognitive-Behavioural Therapy for Anxious Children: Therapist Manual: Third Edition.* Ardmore: Workbook Publishing.

Kendall, P. C., & Hedtke, K. A. (2006b). *The Coping Cat Workbook: Second Edition.* Ardmore: Workbook Publishing.

GAD

Borkovec, T. D., & Sharpless, B. (2004). Generalized Anxiety Disorder: Bringing Cognitive Behavioral Therapy into the Valued Present. In S. Hayes, V. Follette, & M. Linehan (Eds.), *New directions in behavior therapy.* New York: Guilford Press.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals.* Westport, CT: Praeger Publishers.

Borkovec, T. D. Protocol manuals Combined self-control desensitisation and cognitive therapy manual Applied relaxation and self-control desensitisation

OCD

Salkovskis, P. M (1999). Understanding and treating obsessive compulsive disorder *Behavior Research and Therapy, 37*, S29-52.

Bolton, D., Williams, T., Perrin, S., Atkinson, L., Gallop, C., Waite, P., & Salkovskis, P. M. (2011). Randomized controlled trial of full and brief cognitive-behaviour therapy and wait-list for paediatric obsessive-compulsive disorder.*Journal of Child Psychology and Psychiatry*, *52,* 1269-1278.

March, J. S., & Mulle, K. (1998) *OCD in Children and Adolescents: A Cognitive-Behavioural Treatment Manual.* New York: Guilford Press.

Waite, P. & Williams, T. (2009). *Obsessive Compulsive Disorder: Cognitive Behaviour Therapy with Children and Young People. CBT with children, adolescents and families*. Hove: Routledge.

PTSD

Ehlers and Clark (2000) model and treatment protocol, adapted for young people (Smith et al. 2007, 2010).

Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319-345.

Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., Fennell, M., & Grey, N. (in press). Cognitive Therapy for Posttraumatic Stress Disorder: a therapist's guide. Oxford: Oxford University Press.

Smith, P., Perrin, S., Yule, W., & Clark, D.M. (2010). *Post-Traumatic Stress Disorder – CBT with children and young people*. Hove: Routledge.
Smith, P., Yule, W., Perrin, S, Tranah, T., Dalgleish, T., & Clark D.M. (2007). Cognitive behavioural therapy for children and adolescents – a preliminary randomised controlled trial. J*ournal of the American Association for Child and Adolescent Psychiatry, 46*, 1051-1061

Panic

Clark, D.M. (1996) Panic Disorder: From Theory to Therapy. In: Salkovskis, P.M. (Ed) *Frontiers of Cognitive Therapy*. New York: The Guilford Press.

Clark, D.M. (1986) A cognitive approach to panic. *Behaviour Research and Therapy*, 24 (4), 461-470.

Clark, D.M. and Salkovskis P.M. (in press) *Panic Disorderin* Hawton, K., Salkovskis, P.M., Kirk, J. & Clark, D.M. (Eds). *Cognitive Behaviour Therapy: A Practical Guide* (2nd Edition). Oxford: Oxford University Press.

Separation Anxiety:

Schneider, S., Lavallee, K., (2013). Separation Anxiety Disorder. In Essau, C. A. & Ollendick, T. (Eds). T*he Wiley-Blackwell Handbook of The Treatment of Childhood and Adolescent Anxiety.* Chichester: Wiley-Blackwell.

Schneider, S., Blatter-Meunier, J., Herren, C., Adornetto, C., In-Albon, T., Lavallee, K. (2011). Disorder-specific cognitive-behavioral treatment for Separation Anxiety Disorder in young children: A randomized waitlist-controlled trial. *Psychotherapy and Psychosomatics,* 80, 206-215

Social Anxiety:

Clark, D. M. (2005). A cognitive Perspective on Social Phobia, in Ray. W., Crozier W. R. and Alden, L.L .*The Essential Handbook of Social Anxiety for Clinicians.* Chichester: John Wiley & Sons Ltd.

Specific Phobias

Kirk, J. & Rouf, R. (2004). Specific Phobias. In J. Bennet-Levy, G.Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook (Eds.), *Oxford Guide to Behavioural Experiments in Cognitive Therapy.* Oxford: Oxford University Press.

Ost, L. G. (1989). One session treatment for specific phobias. *Behaviour Research and Therapy, 27,* 1-7.

Depression

The NICE guideline on depression in children and young people (2005 updated 2015) concluded that a number of psychological treatments were helpful as a first line of treatment. Evidence from RCTs was limited for all types of psychological treatments and although CBT had the widest range of research evidence the results from studies on CBT were mixed. Overall, there is not sufficient evidence to suggest that CBT is clearly superior to a number of other psychological treatments such as IPT, psychotherapy or family therapy. Research findings since 2007 have not radically altered the evidence base used by the NICE guidance group.

The on-going large RCT in the UK (**the IMPACT study**) comparing CBT, child psychotherapy and psychiatric management will add significantly to our knowledge of the effectiveness of these three treatments with clinically referred children and young people.

For the treatment of depression, Child IAPT workers will be trained in the NICE guidance (2015) including, for example, recognising the need for psychiatric review and consideration of medication as an adjunct to psychological therapy. Within this framework, Children and Young People's IAPT workers will be trained to deliver CBT for children and young people. The course will be predominantly focused on depression in adolescence, as it is much more common in adolescents than younger children. IAPT workers will need to be able to adapt the approach to younger children and this will be considered in a specific part of the module. Therefore, the following will be covered within the CYP-IAPT CBT strand.

Brent, D, A.,& Poling, K. L. S. W. (1997). *Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth.* Star Centre Publications (for clients aged 13-18 years).

Harrington, R., & Wood, A. (1996). *Cognitive-Behavioural Manual for use with Child Patients with Depressive Disorders*. (for clients aged 9-17years)

IMPACT Trial (2010). A manual for the delivery of CBT in the treatment of young people with depression (unpublished draft).

Martel, C.R., Addis, M.E., & Jacobson N. S. (2001). Depression in Context; Strategies for Guided Action New York: W. W. Norton (adapted for adolescents).

Ritschel, L. A. & Ramirez, C. L. (2011). Behavioral Activation for Depressed Teens: A Pilot Study. *Cognitive and Behavioral Practice 18*, 281–299

NICE Guidelines

CG22

National Institute for Health and Clinical Excellence. (2004). *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. Manchester: NICE.

CG113

National Institute for Health and Clinical Excellence. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care (partial update)*. Manchester: NICE.

CG28

National Institute for Health and Clinical Excellence. (2015). *Depression in children and young people: identification and management in primary, community and secondary care*. Manchester: NICE.

CG31

National Institute for Health and Clinical Excellence. (2005). *Obsessive Compulsive Disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*. Manchester: NICE.

CG 026

National Institute for Health and Clinical Excellence. (2005). *Post-traumatic Stress Disorder: the management of PTSD in adults and children in primary and secondary care*. London: Royal College of Psychiatrists and British Psychological Society.

CG159

National Institute for Health and Clinical Excellence. (2013). *Social Anxiety Disorder: recognition, assessment and treatment*. Manchester: NICE.

Framework

- CAMHs Competency Framework (.pdf)
- CBT Competency Framework (.pdf)

Tutorials

There are three types of tutorials in the programme:

1. Whole group academic tutorials/teaching:

Purpose

- Opportunity to reflect on any HW set
- Opportunity to review literature
- Opportunity to ask questions, give and receive feedback
- Opportunity to address any queries around assessments

2. Whole group clinical skills based tutorials

Purpose

- To consolidate learning from workshops
- To provide opportunity for further skills practice

- Opportunity to reflect on any HW set
- Opportunity to ask questions, give and receive feedback

3. Individual tutorials

1 x half hour tutorial per term

Purpose

- Opportunity to review and reflect on your development and the course
- Opportunity to give and receive feedback on assessed work.
- Opportunity to give and receive feedback on the course.
- To review your clinical portfolio.
- A safe environment for addressing personal development.

NB: *If trainees have any concerns or issues that may be impacting on their ability to participate fully in the training or causing them any distress or concern; trainees are strongly encouraged to notify either their tutor or any member of the course team as soon as possible, rather than wait for their 1:1 tutorial.*

Preparation

Trainees are required to bring up to date forms each term for their individual tutorials, to include where appropriate:

- Reflective Practice Summary
- Clinical Log
- Supervision Log
- Teaching Log
- Supervisors Reports

Forms

- 1:1 Tutorial Termly Review (.pdf)
- Portfolio review

Supervision

Throughout the course trainees receive group supervision from course supervisors within the university and from their workplace based supervisors. **Please see separate Supervision Guide and Clinical Portfolio for details of supervision**. Should there be any difficulties that arise within your supervisory relationship, in the first instance please try to work with your supervisor to address these. If difficulties continue, please discuss this with your 1:1 tutor or the Programme Lead. We normally change groups and supervisor at university after the first term – there are no further changes after that.

Confidentiality and Anonymisation

Maintaining confidentiality is a vital aspect of maintaining professional standards. Common over-sights by trainees are the inclusion of identifying information in an appendix (e.g. name of service; identifying information of client or professionals involved), providing excessive information about client and family or geographic location. When writing, always ask yourself if you need to include that bit of information, and if so, is it possible to anonymise it more – for example: X lived in a rural county rather than saying Somerset; a counselling service in the South West of England, rather than saying Checkpoint or Off the Record.

A brief statement in the introduction to case reports and other client-related assessments should make it clear that any names being used have been changed to protect the confidentiality of children and young people and their families/parents/carers. Care should be exercised in anonymising documents included as appendices to reports and other written assessments, especially documents included in the clinical portfolio. Any details that identify

a child or young person or a parent/carer should be deleted or blanked out. If using a felt-tip pen to blank out these details **DO** make sure that the details cannot still be read when the paper is held up to the light, for example. Other names and addresses (apart from the trainee's own name and employing service for the clinical portfolio) should also be blanked out – e.g. names and addresses of GP surgeries. Service details should **NOT** be identified at all for case presentations and case reports. It is also good practice not to include information that might identify the author of assignments, such as details of their profession, for example.

Any breaches in confidentiality in any assessments will result in the assessment automatically being returned to the trainee for urgent attention, or will result in a fail if a serious breach – see below.

You are expected to seek parent / carer consent in every instance possible, alongside consent from all young people. Where parent / carer consent is not possible, for example when a young person is over 16 years or considered Gillick competent and where a parent / carer is not involved in their treatment, it is acceptable to submit a consent form for the young person only. In this case, please state clearly in your submission why parental consent was not sought and how Gillick competence was considered (if relevant).

The following principles have been agreed as the process to follow where there are breaches in confidentiality in assessments submitted as part of the CEDAR PGT training programmes:

<u>Case presentations:</u>

1. With case presentations, no identifiable information should be presented on the client or the service.
2. A minor breach in case presentations, where confidentiality/anonymisation has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The trainee will have 48 hours to reply and correct the errors in the presentation handouts, otherwise it will be marked as a fail.
3. When major breaches are present or anonymisation has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are other resubmission criteria).

<u>Case Reports:</u>

1. In Case Reports there should be no identifiable information in relation to the client or service.
2. A minor breach in Case Reports, where confidentiality/anonymisation has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The Trainee will have 48 hours to reply and correct the errors, otherwise it will be marked as a fail.
3. When major breaches are present or anonymisation has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are other resubmission criteria).

Clinical Portfolios:
1. In the clinical portfolio, the trainee and the service can be identified but no identifiable information on clients should be included.
2. If confidentiality breaches occur in a clinical portfolio in relation to clients, this will be marked as an automatic fail and the trainee will be asked to address the area of concern (and any other changes) for resubmission.

Assessment

Documents available to download:

- CEDAR Mitigation Request Form
- CEDAR Supplementary Form for Clinical Assessments

Module Code	Module Name	Assessment Element	% of Marks	Cohort 12 deadline	Consent Forms
PYCM028	CBT	KSA Draft	N/A	2nd February 2024	
PYCM027	Core Skills	Evidence-based theory essay (3000 words)	30%	8th March 2024	

PYCM028	CBT	Case Presentation - **NB:** Please submit slides by 9am on 29/04/24	15%	29th April 2024	√
PYCM028	CBT	Competency recording A, CTSR Self-Rating (Log A) & Reflective Log B (1000 words)	10%	10th May 2024	√
PYCM028	CBT	FORMATIVE - University Supervisors Report	N/A	3rd April 2024	
PYCM028	CBT	FORMATIVE - Workplace Supervisors Reports	N/A	3rd April 2024	
PYCM027	Core Skills	FORMATIVE - Workplace Supervisor rating of Core Therapy Competencies A (CAPS)	N/A	3rd April 2024	
PYCM028	CBT	Formative KSA 1-4	P/F	24th May 2024	
PYCM028	CBT	Case Report A (3000 words)	15%	31st May 2024	√
PYCM027	Core Skills	Workplace Supervisor Rating of Core Therapy Competencies B (CAPS Report)	20%	5th July 2024	
PYCM028	CBT	FORMATIVE - University Supervisors Report	N/A	05 July 2024	
PYCM028	CBT	FORMATIVE - Workplace Supervisors Reports	N/A	05 July 2024	
PYCM028	CBT	Competency recording B, CTSR Self-Rating (Log A) & Reflective Log B (1000 words)	10%	05 July 2024	√
PYCM028	CBT	Case Report B (3000 words)	15%	30th August 2024	√
PYCM028	CBT	Formative KSA 5-10	P/F	30th August 2024	

PYCM027	Core Skills	Core Reflective Summary (2000 words)	30%	4th October 2024	
PYCM028	CBT	Formative KSA 11- 13	P/F	25th October 2024	
PYCM028	CBT	Competency recording C, CTSR Self-Rating (Log A) & Reflective Log B (1000 words)	10%	25th October 2024	√
PYCM028	CBT	Extended Case Report C (5000 words)	25%	8th November 2024	√
PYCM027	Core Skills	Workplace Supervisor Rating of Core Therapy Competencies C (CAPS report)	20%	6th December 2024	
PYCM028	CBT	SUMMATIVE - University Supervisors Report	N/A	6th December 2024	
PYCM028	All Students	SUMMATIVE - Workplace Supervisors Reports	N/A	6th December 2024	√
PYCM028	CBT	Clinical Portfolio	P/F	17 January 2025	
PYCM028	CBT	KSA Portfolio	P/F	24 January 2025	

*You can expect to receive your results 15 working days after your deadline, 20 working days for tape submissions, or 6 weeks for KSA portfolios. Please note that if you have mitigated your submission, this will be 15/20 working days after your set deadline, not the original deadline. If your work is submitted late without an authorised extension, but within the 14 day late period, this work is not included in the 15/20 working day guarantee.

Please note for submissions that require a consent form, the consent form must also be submitted by the submission deadline. If you believe you have grounds for an extension, please see the "mitigation requests" page for more information.

Formative and Summative Assessments Guidance and Marking Criteria

- Case Presentation
- Case Reports (each on a different case):

- Case reports A and B
- Case Report C (Extended Case Report)
- Practice Competency Tapes and associated Reflective Practice Log and self-rating CTSR.
- Clinical Portfolio and Supervisor's Reports (see separate Clinical Portfolio handbook) - including summary logs of clinical activity, case summaries, taught hours log, ELE feedback, self ratings and reflective summaries, supervision log and supervised practice summary sheet.
- KSA portfolio (see separate Clinical Portfolio handbook – for trainees without a core profession)
- Workplace Service Leads and workplace Supervisors will be routinely informed of trainees' marks on their academic assignments (e.g. essays, case reports) and clinical assignments (e.g. competency CTS-R assessments). Workplace Service Leads and Supervisors are invited to make contact with the Programme Lead and Academic Lead should any concerns about a trainee's development arise throughout the year.

If you have difficulties with written assessments please use the University study skills department: www.exeter.ac.uk/student-engagement-skills/academic/.

Note regarding Case Presentations and Reports

In terms of the BABCP's accreditation requirements, 4 case reports are required, and the initial Case Presentation counts as one of these reports for accreditation purposes. Trainees should also note that the case presentation and case reports MUST each describe a different case, and that a range of presenting difficulties is expected across the presentation and reports. The case presentation can describe work with either depression or an anxiety disorder, for example. Of Case Reports A and B however, one of these MUST describe work with a depression case. Case Report C can again describe work with either depression or an anxiety disorder, although it would not be acceptable for instance, for the presentation, Case Report A/B and Case Report C to all describe depression work.

In the same way, a range of anxiety disorders is also expected – three reports all describing work with social anxiety would not be acceptable either. If trainees have any doubts or questions regarding the content of their presentations of case reports, they should approach a member of the academic team as early as possible for advice and guidance.

Assessment and Formulation Case Presentation

CBT trainees give one case presentation, which can be of a client with either anxiety or depression.

The case presented must be one of your closely or non-closely supervised cases in the clinical portfolio. This means that you must have completed AT LEAST 5 sessions with the client and had 5 hours of supervision (university OR workplace). Although these 5 sessions do not have had to have been completed prior to the case presentation, it will be helpful if

they have as it avoids the risk of the client dropping out after the presentation and this case then NOT meeting the criteria for inclusion in the portfolio and subsequently not then meeting the criteria for the case presentation.

The purpose of the case presentation is to demonstrate trainees' grasp of the application of cognitive–behavioural or social learning theory to clinical practice and to demonstrate their skills in assessment and formulation.

Please note: your Powerpoint slides will need to be submitted to BART by **9am** on the morning of your presentation.

Guidelines

Trainees will be assessed on the following dimensions:

***Assessment**

Should include:

- Reason for referral and for seeking treatment at this point.
- Presenting problem(s), diagnosis and co-morbidity.
- Relevant background/personal information, including development of the problem, predisposing and precipitating information, and current social circumstances.
- Risk assessment (give some detail of how risk was assessed, including any particular tool or protocol that was used)
- Identified treatment goals for therapy (focus on SMART goals).
- Issues relating to engagement and the therapeutic alliance.
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used, reasons for this should be given).
- A cognitive behavioural or parenting assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours.
- Socialisation to the model and suitability for CBT/introduction to parenting programme.
- Scores on IAPT service outcome and assessment measures.
- Relevant disorder specific assessment questionnaires (if not a reason should be given).

***Conceptualisation / Formulation**

- Where a particular model has been used to guide formulation this should be referenced and accurately described.
- There should be a description of the case conceptualisation and clarified, where possible, by a diagrammatic representation of the conceptualisation.
- Ensure that the arrows on any diagrammatic formulations should make sense, flow accurately and reflect both the theory and actual experience of the client.
- The formulation should link and explain the presence of maintenance factors of the presenting problem(s) and where relevant the development of the problem.
- The formulation should relate to the client's goals and flow from the assessment.
- Ensure a focus on collaboration with explicit client contribution.

***Intervention Plan**

The intervention plan should:

- Relate to the client's identified goals.
- Directly relate to and flow from the case conceptualisation.

- Include reference to relevant NICE guideline / manuals / models(s).
- Identify anticipated difficulties, guided by the assessment and formulation process.

*Link of theory to practice

This is covered to some extent in previous areas.

Throughout the presentation you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural/social learning theory and relevant models.
- Use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case.
- Refer to and make use of the relevant literature pertaining to this case.

Self reflectivity

Throughout the presentation you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process. For example we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future. You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, thought records, listening to session recordings etc.).

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, e.g. awareness of:

- Issues of risk
- Ethical issues
- Power dynamics
- Issues of diversity and difference and its impact on the therapeutic relationship.
- Client confidentiality - anonymised biographical data must be used throughout the presentation, i.e. you need to change any names and identifying information and make it clear that this has been done.

Structure and style of presentation

Marks will be awarded for a well-structured and well-presented case presentation. Use of PowerPoint is strongly encouraged and PowerPoint slides (or equivalent document) should include prompts/bullet points to aid presentation and discussion of the case. The case presentation should flow in a logical manner and any slides/hand-outs provided should be relevant and aid the markers. **The slides will be required to be submitted to the markers following the presentation.** Be mindful of your use of language, both regarding the use of colloquialisms and jargon. Where appropriate you may make use of diagrams, tables and bullet points in the presentation to clarify information. A possible structure could be based on the marking criteria e.g.: Introduction to the presentation, reason for referral, presenting

problem(s), assessment, formulation, intervention plan and critical evaluation/discussion. Theory to practice links, self-reflectivity and professional issues could be covered throughout the presentation. Your case presentation should be clearly presented and you may wish to consider practising your presentation beforehand where possible. Consider any preparation time needed for the set-up of your presentation as this should be kept to a minimum. Put any aids (e.g. PowerPoint document) onto a memory stick and position any other aids needed (e.g. flipchart, handouts) at the beginning of your presentation.

References

References should be given throughout the presentation and provided on a slide at the end. For simplicity of visual presentation, references in the presentation slides can be shortened to 'et al.'. Reference section at the end MUST conform to APA guidelines. Please check and double check references in terms of accuracy, consistency and ensuring that all references in the presentation slides/text are referred to in the reference section.

Spelling, grammar, typographical errors

You will be marked down for typographical, grammatical and spelling errors on any slides/hand-outs you provide. If you have problems in this area please use the study skills department.

Length of Presentation

The case presentation should be a maximum of 25 minutes' duration. A further 5 minutes can be spent on questions by the panel for clarification purposes only. No follow-on questions will be permitted; therefore all relevant clinical information will be required within the case presentation. **The presentation will be halted at 25 minutes and information not presented will not receive credit.**

Re-submission Criteria

Key areas of the presentation are indicated by an asterisk (*), and include the following: Assessment, Conceptualisation/Formulation, Intervention Plan, Link of Theory to Practice. A failure on one or more of these key areas is likely to result in the failure of the overall presentation. Failure may result from the complete omission of an area, or because the standard of what has been included is not satisfactory. In the case of an overall fail, the trainee will be required to provide either a re-submission, or an additional written update as advised by the marker.

Files to download:

- Case Presentation Mark Sheet 2023

CBT Case Reports

Trainees submit three case reports over the year on three *different* clinical cases.
Case Reports A & B (3,000 words)
This will be with one client with anxiety and one with depression.

Aims
The purpose of these case reports is to demonstrate your grasp of the application of theory to clinical practice.

Extended Case Report C (5000 words)
This can be of a client with either anxiety disorder (with a different presentation to case report A/B) or depression.

Aims
The overall aims of the extended case report are for you to demonstrate your grasp of the application of theory to clinical practice by demonstrating an understanding of evidence-based practice and providing a critical discussion of the relevant research evidence to this case/group.

You will be required to reflect on one or two key themes or issues that were apparent or relevant to this case and discuss these with reference to relevant research/literature. You may wish to include transcript of sessions from this client/group to illustrate your points and provide material for reflection. The area chosen may relate to any area of CBT and clinical work. Examples might include different cognitive-behavioural models, process issues, issues relating to the therapeutic alliance, contextual or systemic factors cultural or difference issues.

N.B. A good case does not necessarily mean one with a good outcome. We require you to demonstrate not just your application of CBT theory to clinical practice but also your reflections and learning related to this piece of clinical work and your understanding of evidence-base practice.

NB In all case reports material presented must reflect accurately the assessment and interventions carried out with the relevant client.

CYP IAPT CBT Consent for Recording, Supervision & Case Reports - Parent/Carer
CYP IAPT CBT Consent for Recording, Supervision and Case Reports-Child

Case Report Marking Criteria

Please also refer to University guidelines on written material.

Range	Case Report A and B	Extended Case Report C

Distinction 70-100%	Work of exceptional standard reflecting outstanding competence/knowledge of material and critical ability above and beyond those required for a pass mark.	As in previous Case Reports
Merit 60-69%	Work with a well-defined focus, reflecting a good working competence/knowledge of material and a good level of competence in its critical assessments and beyond those required for a pass mark.	As in previous Case Reports
Pass 50-59%	Work demonstrating adequate competence/working knowledge of material and evidence of some analysis. Work adheres to the relevant NICE or clinical guideline. A piece of work in this category should include the following (unless a clear rationale for exceptions is given): Reason for selecting this case, the presenting problems should be clearly identified and described with goals for therapy included. Where available an appropriate model should be used. The assessment should include factors relevant to the development and maintenance of the difficulties. Where appropriate the relevant disorder specific assessment and outcome tools should be used as well as IAPT required measures. A formulation should be present in diagrammatic **and** written form. This formulation should flow logically from assessment and include precipitating and maintaining factors and where appropriate predisposing/developmental factors. The intervention plan should be clearly described and flow logically from formulation. The interventions should be clearly described, have clear rationale and flow logically from formulation. Outcome of the intervention should be described and evaluated. There should be some critical analysis and reflection on the work and the therapeutic alliance. Throughout the	As in previous Case Reports and additionally: You will need to clearly identify and reflect on one or two key themes or issues that were apparent or relevant to this case and discuss these with reference to relevant research/literature. It should demonstrate clear understanding of evidence base practice and provide a critical discussion of the research evidence base in relation to both the work carried out and the specific theme(s) chosen for the reflective analysis.

	report, a professional and ethical stance should be demonstrated. References and awareness of relevant literature generally accurate but limited. Adheres to word count.	
Condonable Fail 40-49%	Limited competence/knowledge of core material and limited critical ability. Poorly written and presented/structured piece of work. Rationale and arguments are absent or problematic. Inappropriate application of theory to practice. References may not have conformed to University guidelines.	As in previous Case Reports
Fail 0-39	Lacking in basic competence/knowledge of core material and absence or major flaws in critical analysis. Unethical practice, breaches in confidentiality.	As in previous Case Reports

Case Report A & B Guidelines (3,000 words) - CBT

You will be assessed on the following dimensions:

***Assessment**
Should include: • Reason for referral. • Presenting problems (n.b. use of multiple informants) • Goals for therapy. • Reference to relevant NICE guideline. • Issues relating to engagement and the therapeutic alliance. • Use of the relevant referenced model to guide assessment, formulation and intervention (if it is not used reasons should be fully explained). • Relevant background information, predisposing and precipitating information. • A cognitive behavioural/parenting assessment of the presenting problem. • Scores on IAPT service outcome and assessment measures. • Relevant disorder specific assessment questionnaires (if not a reason should be given). • Risk assessment (give some detail of how risk was assessed, including any particular tool or protocol that was used)
***Conceptualisation / Formulation**
• Where a particular model has been used to guide formulation this should be referenced. • Arrows on diagrammatic formulations should make sense and flow. • Diagrammatic formulations should be used to help clarify formulation within the text. • The formulation should link and explain the presence of and maintenance of the presenting problem and where relevant the development of the problem • The formulation should relate to the client's goals and flow from the assessment. • Where relevant, reformulation should be included.
***Intervention**

- Interventions (carried out or planned) should relate to and flow from the client's goals and the formulation and be in line with CYP IAPT evidence based practice
- Rationales for the interventions carried out should be present.
- Enough detail should be given so that it is clear what was done, but blow-by-blow account of each session is not needed.

***Critical evaluation/outcome**

- You need to evaluate the interventions as applied and the outcome of the case.
- You need to demonstrate that evaluation is not something that is done just at the end of an intervention, but throughout the course of therapy so that you know you are on track.
- Present CYP-IAPT service outcomes for the client, and provide interpretation of what these mean
- You should re-administer and report on all measures that were used at assessment (if not a reason should be given).
- Outcomes should be clearly related back to the identified goals of therapy.
- You should critically evaluate the outcome to date - e.g. why you think the changes made have occurred? Or, if no changes have occurred why this may be? Where possible relate this back to the case conceptualisation and/or the theory/model.
- Where the case has not been completed you need to present the current outcome in relation to the identified goals.

***Link of theory to practice**

This is covered to some extent in previous areas. You should relate the clinical work carried out to relevant cognitive theory and relevant models. You should use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case. You should refer to and make use of the relevant literature pertaining to this case.

Self reflectivity

You should demonstrate a reflective approach to the work carried out and the use of methods / tools to aid this process. For example we would expect you provide rationales for the work carried out that draws on your ability to reflect on theory/ therapeutic alliance/socio- political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your thoughts/assumptions/beliefs impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future? You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, thought records, listening to session recordings etc.).

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, (e.g. good awareness of issues of risk, awareness of ethical issues and awareness of power dynamics). You should demonstrate an awareness of issues of diversity and difference and its impact on the therapeutic relationship. **NB** You need to make it clear that names and identifying information has been changed. A statement on the submission cover page will suffice.

Structure and style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language both the use of colloquialisms and jargon. Where appropriate you may use diagrams, tables and bullet points. These should be used to aid clarity. If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Key information needs to be in the main body of the text. Appendices should be clearly referred to and labelled and come after references. A possible structure could be based on the marking criteria e.g.: reason for referral, presenting problem(s), assessment, formulation, intervention plan and critical evaluation. Theory to practice links, self reflectivity and professional issues could be covered throughout in the previous sections or as separate sections.

References

References MUST conform to APA both in text and at the end of your case report (see University guidance). Please check and double check references in terms of accuracy, consistency and ensuring that all references in the text are referred to in the reference section.

Spelling, grammar, typographical errors and presentation

You will be marked down for typographical, grammatical and spelling errors. Work should be double spaced and page-numbered. Where available get someone else to proof read your essay before submitting. If you have problems in this area please use the study skills department.

Word count

Word count excludes: case report title, tables, the reference list, figures and appendices. **All other words are counted. Work exceeding this limit will not be marked and will not receive credit.**

Resubmission Criteria

Key areas of the report are indicated by an asterisk (*), and include the following: Assessment, Conceptualisation/Formulation, Intervention, Critical Evaluation/Outcome, Link of Theory to Practice. A failure on one or more of these key areas will result in the failure of the overall case report. Failure may result from the complete omission of an area, or because the standard of what has been included is not satisfactory. In the case of an overall fail, the trainee will be required to provide a written re-submission, details of which will be advised by the marker.

- Case Report A and B Mark sheet

Extended (5,000 word) Case Report C Guidelines - CBT

You will be assessed on the following dimensions:

***Assessment**

Should include:

- Reason for referral.
- Presenting problems (n.b. use of multiple informants)
- Goals for therapy.
- Reference to relevant NICE guideline.
- Issues relating to engagement and the therapeutic alliance.
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used reasons should be fully explained).
- Relevant background information, predisposing and precipitating information.
- A cognitive behavioural/parenting assessment of the presenting problem.
- Scores on IAPT service outcome and assessment measures.
- Relevant disorder specific assessment questionnaires (if not a reason should be given).
- Risk assessment (give some detail of how risk was assessed, including any particular tool or protocol that was used)

***Conceptualisation / Formulation**

- Where a particular model has been used to guide formulation this should be referenced.
- Arrows on diagrammatic formulations should make sense and flow.
- Diagrammatic formulations should be used to help clarify formulation within the text.
- The formulation should link and explain the presence of and maintenance of the presenting problem and where relevant the development of the problem
- The formulation should relate to the client's goals and flow from the assessment.
- Where relevant, reformulation should be included.

***Intervention**

- Interventions (carried out or planned) should relate to and flow from the client's goals and the formulation and be in line with CYP IAPT evidenced based practice
- Rationales for the interventions carried out should be present.
- Enough detail should be given so that it is clear what was done, but blow-by-blow account of each session is not needed.

***Critical evaluation/outcome**

- You need to evaluate the interventions as applied and the outcome of the case.
- You need to demonstrate that evaluation is not something that is done just at the end of an intervention, but throughout the course of therapy so that you know you are on track.
- Present CYP-IAPT service outcomes for the client, and provide interpretation of what these mean.
- You should re-administer and report on all measures that were used at assessment (if not a reason should be given).
- Outcomes should be clearly related back to the identified goals of therapy.
- You should critically evaluate the outcome to date - e.g. why you think the changes made have occurred? Or, if no changes have occurred why this may be? Where possible relate this back to the case conceptualisation and/or the theory/model.
- Where the case has not been completed you need to present the current outcome in relation to the identified goals.

***Link of theory to practice**

This is covered to some extent in previous areas. You should relate the clinical work carried out to relevant cognitive theory and relevant models. You should use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case. You should refer to and make use of the relevant literature pertaining to this case.

***Critical appraisal of themes**

You need to clearly identify one or two key themes or issues that were apparent or relevant to this case and critically appraise these with reference to relevant research/literature. You should take an objective and critical stance to the work carried out

Self reflectivity

You need to demonstrate a reflective approach to the work carried out and the use of supervision to aid this process, **specifically in relation to your chosen theme(s**). For example, we would expect you provide rationales for the work carried out that draws on your ability to reflect on theory/ therapeutic alliance/socio-political/organisational/professional and ethical factors. Reflection may involve demonstrating an awareness of the way that your thoughts/assumptions/beliefs impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future? You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, thought records, listening to session recordings etc.). You may wish to include transcript of sessions with this client to illustrate your points and provide material for reflection.

Awareness of professional issues (including confidentiality)

Your work should demonstrate good professional awareness, (e.g. good awareness of issues of risk, awareness of ethical issues and awareness of power dynamics). You should demonstrate an awareness of issues of diversity and difference and its impact on the therapeutic relationship. **NB** You need to make it clear that names and identifying information has been changed. A statement on the submission cover page will suffice.

Structure and style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language both the use of colloquialisms and jargon. Where appropriate you may use diagrams, tables and bullet points. These should be used to aid clarity. If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Key information needs to be in the main body of the text. Appendices should be clearly referred to and labelled and come after references. A possible structure could be based on the marking criteria e.g.: introduction to the case and key themes that will be discussed, reason for referral, presenting problem(s), assessment, formulation, intervention plan and critical evaluation and reflective analysis. Theory to practice links, self reflectivity and professional issues could be covered throughout in the previous sections or as separate sections. The case report should address the aims of the assessment

References

References MUST conform to APA both in text and at the end of your case report (see University guidance). Please check and double check references in terms of accuracy, consistency and ensuring that all references in the text are referred to in the reference section.
Spelling, grammar, typographical errors and presentation
You will be marked down for typographical, grammatical and spelling errors. Work should be double spaced and page-numbered. Where available get someone else to proof read your essay before submitting. If you have problems in this area please use the study skills department.
Word count
Word count excludes: case report title, tables, the reference list, figures and appendices. **All other words are counted. Work exceeding this limit will not be marked and will not receive credit.**
Resubmission Criteria
Key areas of the report are indicated by an asterisk (*), and include the following: Assessment, Conceptualisation/Formulation, Intervention, Critical Evaluation/Outcome, Link of Theory to Practice, Critical Appraisal of Themes. A failure on one or more of these key areas is likely to result in the failure of the overall case report. Failure may result from the complete omission of an area, or because the standard of what has been included is not satisfactory. In the case of an overall fail, the trainee will be required to provide a written re-submission, details of which will be advised by the marker.

- Case Report C Marksheet 1

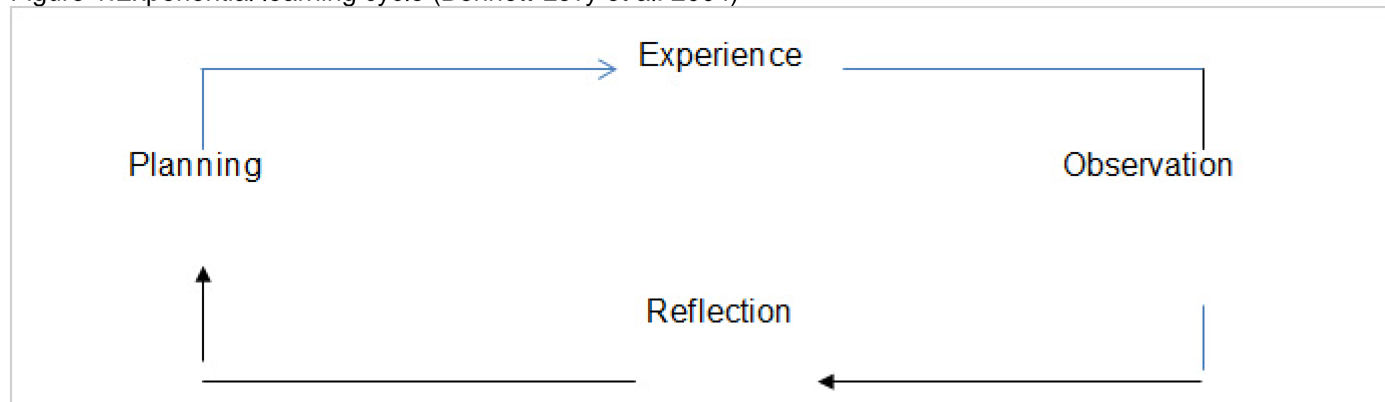
Reflective Practice Summary

You will be required to submit a reflective summary Log B with your three competency tapes. Each summary should be up to 1000 words.

You may choose to reflect on one particular part of the session or reflect on the session as a whole. We would expect you to identify the area that you are going to reflect on and then provide a reflective analysis of this area followed by a plan. Your analysis should demonstrate your ability to reflect on your practice and in particular in relation to the formulation of this client's presentation. The analysis should provide a critical evaluation of the therapy skills that you demonstrate within the recording, drawing on relevant CBT/Parenting theory, research and literature and identify areas for improvement. The following model may be help with this. You should make reference to your self-rating forms within the summary.

The four stage experiential learning model (Kolb 1984 and Lewin 1946) in Bennett-Levy et al (2004 p. 19) is the most widely used model in adult education (see fig. 1).

Figure 1.Experiential learning cycle (Bennett-Levy et al. 2004)



Different terms have been used by different authors to reflect the same four stages. Plan, Experience, Observe, and Reflect.

Effective learning is said to proceed through a series of these cycles.

EXPERIENCE: The experience
OBSERVE: What happened
REFLECT: Making sense of what happened by

- Relating it to previous experience and knowledge
- Searching for understanding
- Generalising, abstracting principles
- Fit with the formulation

PLAN: With the new understanding, how can I take this forward?
Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, 29, pp. 203-220.

Criteria for Assessing Reflective Log
During your training you will complete:

- Three Reflective Log Bs on your CBT specific competencies. These are handed in with your three competency tapes. These will be marked as pass / fail (satisfactory / Unsatisfactory)

The purpose of the Reflective Logs and Summary is to demonstrate your ability to:

- Reflect on your experience of practice
- Critically analyse and make sense of that experience (informed by theory and literature where appropriate)
- Extract useful learning and plan for change to help with competency development

You will be assessed on the following dimensions:

Introduction of topic of reflection
• Clear identification of one or two issues relevant to the session • Description of reflective process (e.g. may have involved the use of a model such as Kolb's learning cycle, discussion with supervisor, use of thought records, reflective team etc.)
Experience and observation
• Description of the relevant concrete experience within the session / your practice e.g. client / family and therapist behaviour, verbal communications and events. • Observations of therapist reactions, automatic thoughts, emotions and impulses (where relevant).
Critical analysis
• Analysis of experience and observations within the session and beyond taking an objective and critical stance and presentation of alternative interpretations. • Analysis should be informed by client / family (and/or where applicable therapist) formulation.
Understanding and use of theory
• Integration of critical analysis with existing knowledge of CBT • Integration of critical analysis with relevant CBT literature and research where appropriate
Summary and implications for future practice
• Summary of learning • Description of plans for active experimentation, further learning and clinical practice (including awareness of own assumptions etc.)
Structure & style
• Clear structure with a logical flow • May use existing models of reflection such as Kolb's learning cycle to structure
Spelling / Grammar / Typos
• You will be marked down for errors. • References - Where reference to theory is made, references should conform to APA guidelines.

Documents

- Reflective Log B Mark sheet
- Reflective Practice Summary (Log B) guidelines
- Guidance on Writing Reflective Practice Log (.pdf)

CBT Competency Tapes

You will have to submit **three** therapy video recordings over the year. An appropriate consent form(s) and front sheet should be included. You will also need to submit a CTSR and reflective log when you submit a tape. Competency tapes are assessed using the CTSR scale and you will be supported through the course to understand how your practice will be assessed alongside the core skills in delivering good CBT. Should issues of risk be identified in a CTSR submission which are not adequately dealt with in session the tape will automatically fail.

For CBT, in order to reduce your workload where possible these recordings should be of those clients you wish to use as your closely supervised cases (see supervision handbook section for details). These will be the cases you bring to the university supervision.

Please note that recorded sessions should not exceed 60 minutes. Marking will stop at 60 minutes and no credit will be given for any work beyond that point*. If the work underway is part of a recognised PTSD protocol, then exceptionally sessions up to 90 minutes would be accepted. This would need to have been agreed in advance with your university supervisor however, so that the course team is aware of the situation at the time your recording is submitted.

Guidance on Recording Sessions

It is standard practice to record therapy sessions that can be given to the client to listen to between sessions.

You will be expected to submit videos as part of the clinical assessment and bring these to supervision. It is essential that you obtain the consent of your client and parents for the recording to be used for supervision and/or assessment and submit this with your recording. The consent form also asks whether your client will be willing for the recording to be used in future training. You should consult your placement supervisor about your Trust's policies on storing the recordings and transporting the clips and submissions to the University.

Recording Equipment

All Trusts should provide trainees with recording equipment to make and transport video recordings securely.

Marking Criteria

For CBT tapes the competency tape mark sheet

A pass mark of 50% on this measure will need to be achieved on the two summative tapes. On the CTS-R this corresponds to a raw score of 36 and above (but **must** include a rating of at least 2 on **every** item in order for the tape to pass).

Submission Guidance

Your video tape recordings must be submitted by the deadlines. The videos must be clearly audible and be of a complete session. They must be one continuous, unedited recording. For CBT we recommend that this is a mid-therapy session as this will make it much easier to pass all the required items.

Tape submissions**:** Min requirement: For CTSR submission is that the young person and therapist are at least both partially visible on the recording (for example when young person's back to recording). However, we would recommend (particularly for summative

submission tapes) for trainees to choose a recording where both therapist and young person are clearly visible. This is because it can make it easier for the trainee to best evidence marking criteria in relation to the CTSR. For example, demonstration of how the therapist is guided by and attends to no verbal ques from the young person and how treatment is adapted/tailored to more subtle interactions.

NB: Trainees will need to ensure that the quality of the sound is adequate if the YP Is not facing the camera. Trainees may wish to use external microphones to help with this.

Clips brought to Supervision: Short clips that are shown in supervision (10 minutes or less) CAN be later submitted as a session for the CTSR. Any clips longer than 10 minutes CANNOT be later submitted as a session for the CTSR.

Only supervision questions can be asked in supervision about these clips – no feedback will be given by supervisors in relation to if this would pass CTSR marking criteria.

Any feedback/supervision given by supervisors IS NOT indicative of how the clip will be assessed by markers of the CTSR.

Reflective Log A: Self-rated CTS-R

You will also need to submit a self-rated CTS-R along with your tape. This includes a brief overall self-reflection of your session and your own ratings based on the CTS-R. Further guidance on using the CTS-R to rate a session can be found in the CTS-R manual, which is on your ELE page.

Reflective Log B: Reflective Practice Summary

You will need to submit a 1000 word reflective practice summary with each of your tapes. Further details and guidance can be found on the reflective practice summary page.

Documents

- CYP IAPT CBT Consent for Recording, Supervision & Case Reports - Parent/Carer
- CYP IAPT CBT Consent for Recording, Supervision and Case Reports-Child
- Competency Tape CTS-R Mark sheet
- Competency Tape cover sheet
- Reflective Log A self-rated CTS-R submission form

Supervisor's Reports

At the end of each term your workplace supervisor and university supervisor will write a report on your progress in learning and competence in key aspects of CBT, as well as your use of supervision. These reports provide a great opportunity to review how things are developing and to collaboratively highlight specific targets for learning over the next few months.

The reports for terms 1 and 2 are formative and use a numerical Dreyfus scale to gauge your learning as well as providing qualitative feedback. The report for term 3 is summative – **and this must be passed in order to successfully complete the course.** Qualitative feedback will also be given for this report, although each section will be shown as Satisfactory or Unsatisfactory with an overall pass or fail shown for the report as a whole.

The sections of each supervisor's report are as follows:

- Ability to use supervision
- CBT Assessment and formulation
- CBT Use of theory
- CBT Techniques and skills

The report will also highlight how often recordings have been brought to supervision. The term 3 workplace report will also in addition ask the supervisor to detail what opportunities have been provided for the trainee to observe that supervisor's own CBT practice. This may be sitting in a session 'live' with a supervisor, or being offered video recordings of the supervisor's CBT work to view. Ideally, these opportunities for observation would be offered throughout the year and especially near the beginning of the year.

Your supervisors – both in the workplace and at university – should provide you with an opportunity to discuss the report one-to-one. You are required to add your feedback on the nature and quality of supervision received during the term to the report, as well as an action plan, before submitting the report for the relevant assessment deadline. Details of the exact assessment procedure are provided by the course administrator each academic year.

Please note that the summative term 3 report MUST be included within your clinical portfolio, appropriately signed and dated by yourself and your supervisor. You will have one summative report in term 3 from your workplace supervisor and one summative report in term 3 from your university supervisor. Both must be included in your clinical portfolio.

Where a trainee does not satisfactorily meet the expectations of a supervisor's report, this will be addressed with the trainee and their tutor and supervisor and an action plan drawn up if required. This may need to also involve the trainee's organisational line manager.

Links to download:
Formative Supervisor Report
Summative Supervisor Report (University)
Summative Supervisor Report (Workplace)

Clinical Portfolios

At the end of the year of training, all trainees are required to submit a clinical portfolio in order to pass the course. The clinical portfolio is comprised of two parts:

Part one: Log of Clinical and Supervision Activity (LCSA; Excel file)
Part two: Supporting Documentation

Part one: Log of Clinical and Supervision Activity (LCSA)

Part one of your clinical portfolio is to be completed on the excel file, which can be found on the link below. This is a log of all your clinical and supervision activity throughout your year of training. All trainees are strongly encouraged to start completing this from the outset and to keep it updated. You will be asked to bring this along to your 1:1 tutorials and your supervisors may ask to see this in order to understand how you are progressing. You will be allocated your own individual SharePoint folder which can be access only by you, the course staff and your supervisors. You should use this folder to share the most up to date version of your LCSA.

Please take the time to familiarise yourself with all the tabs on the file. There is an initial instructions tab which outlines clearly how the file should be completed, and where necessary there are further instructions on each tab.

You will need to include confirmation from your supervisors that they have seen and agree with your final LCSA. This should take the form of an email 'signature', using the specific email templates which can be found on the document list below. These must then be inserted into your LCSA, as per the instructions.

Observing others in practice

Observation of supervisor or another experienced therapist. Please include details of all instances where you have had the opportunity to observe others CBT practice throughout the year. Minimum of six observations required throughout the year.

Recording of supervision

During your training you will receive a combination of group and individual supervision, across University and your workplace. Supervision is recording differently depending on whether it is a group or individual format. While recording individual supervision is fairly

straightforward, certain formula need to be applied for group supervision. **In your LCSA, there are clear instruction on how to record supervision and for the most part the calculations are completed automatically for you**. However, for your own understanding the description has been provided:

When calculating supervision hours for your LCSA, it is recognised by the BABCP that time spent in group supervision offers greater value than simply calculating the time spent on an individual case, so the below calculations must be applied:

1. When recording case-specific group supervision related to one of the 8 clinical portfolio cases ('CS Client Summary Sheet', 'NCS Client Summary Sheet' and 'Overall CS / NCS client summary sheet') the following BABCP formula is used:

Time spent discussing a particular case in group supervision is multiplied by two
For example, if there are three participants in a two-hour group and 30 minutes has been spent discussing a case:
30 minutes x 2 = 60 minutes equivalent case supervision time

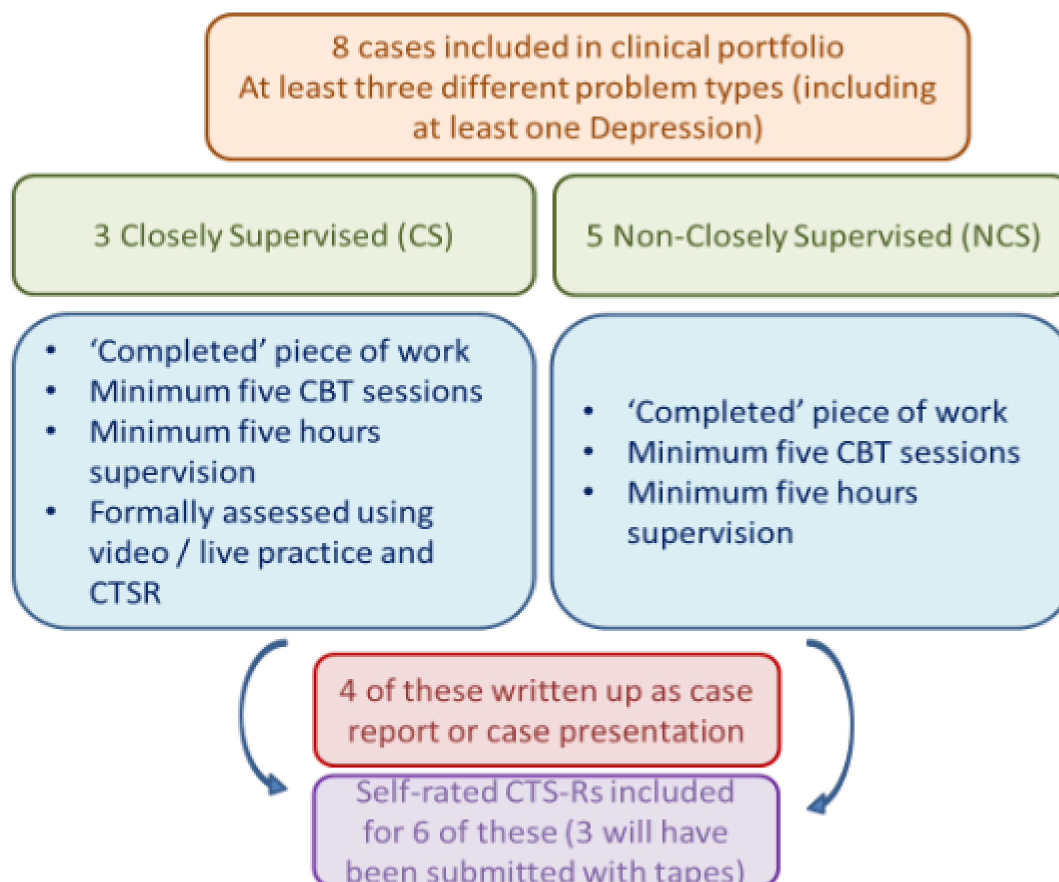
2. When recording group supervision hours on your LCSA supervision logs, the following BABCP formula is applied:

Time spent in the group is divided by the number of participants in the group, and this time is then doubled
For example, if there are 3 participants in the group, and the group meets for two hours; the formula would be:
120 minutes divided by 3 people = 40 minutes x 2 = 80 mins equivalent group supervision time

8 Clinical Cases

In addition to logging all supervision and CBT practice, in your LCSA you will outline 8 cases that you have seen from start to completion. Three of these cases will be closely supervised (CS) and five will be non-closely supervised (NCS). For a case to be closely supervised, you must have had a whole session viewed by a BABCP accredited clinician, with written feedback received based on the full CTS-R. This process is completed when you submit each of your competency tapes and so it follows that your three competency tapes which you submit during your training, should be for one of your closely supervised cases. If you submit a competency tape for a case which you do not intend on including as a closely supervised case, you will need to make alternative arrangements for the CTS-R assessment of your CS case.

The below diagram outlines further details regarding your 8 clinical portfolio cases:



Part two: Supporting Documentation

This part of the clinical portfolio comprises of supporting documentation that cannot be submitted as part of the excel file. When you submit your clinical portfolio, you will have access to a shared online folder, in which you can upload your documents for submission. Within this folder you will need to:

1. Create a subfolder entitled 'Supporting Documents'
2. Within this folder you will need 14 further subfolders, each entitled as outlined below.

Please use the exact wording stipulated below for your folders. If your submission is not set out in this way, we will need to return it to you to amend. This is to ensure that clinical portfolios can be marked efficiently within the time frame and stored electronically in a clear and effective way.

Subfolder Name	Subfolder Contents
Folder 1 Teaching Log	Include: Teaching logs for all three terms Any missed session forms / evidence of learning
Folder 2 CAPS reports	Include CAPS reports for Terms 2 and 3
Folder 3 University Supervisor report	Include Term 3 supervisor report
Folder 4 Workplace Supervisor report	Include Term 3 supervisor report
Folder 5 CS01	Include discharge letter and CHI-ESQ
Folder 6 CS02	Include discharge letter and CHI-ESQ
Folder 7 CS03	Include discharge letter and CHI-ESQ
Folder 8 NCS01	Include discharge letter and CHI-ESQ
Folder 9 NCS02	Include discharge letter and CHI-ESQ
Folder 10 NCS03	Include discharge letter and CHI-ESQ
Folder 11 NCS04	Include discharge letter and CHI-ESQ
Folder 12 NCS05	Include discharge letter and CHI-ESQ
Folder 13 Reflective Log A	Include Six self-rated CTS-Rs: three of these are previous submissio three completed independently
Folder 14 Email signatures	Include: University supervisor email signatures for Clinical Log University supervisor email signatures for Supervision Workplace supervisor email signatures for Clinical Log Workplace supervisor email signatures for Supervision

Related documents

Portfolio & Accreditation_12

Clinical portfolio email signature templates_12

Clinical Portfolio document map_12

Clinical Portfolio_part 1_12

Clinical Portfolio_supporting document submission

Clinical Portfolio Resubmission Form

Clinical Portfolio Feedback

Mitigation Requests

Application for mitigation of assessment should be made prior to the assessment deadline in question, or within 24 hours of the deadline. Please see further guidance in the Generic IAPT Handbook.

Minor ailments, including coughs and colds, and short-term difficulties including those involving transport, computer problems (always make a backup of your work); personal or family celebrations, etc. will not be acceptable as grounds for appeal.

Acceptable grounds for an extension will include serious illness, serious personal problems, and deaths of close family or friends. Appeals should be supported by the relevant documentation, including medical notes, where possible and appropriate.

As a general rule the committee will not accept appeals where the problems could have been resolved and late submission avoided if the programme member had planned ahead by a few days.

Students may apply for mitigation for more than one module where the same circumstances have affected more than one assessment. However, students must use the correct mitigation process and be explicit in detailing: the circumstances that have affected them, how these circumstances have affected their performance and evidence to support their application (doctor's note etc.), together with written corroboration/support from their workplace supervisor.

Students wishing to apply for mitigation for the CYP-IAPT Practitioners course should complete the CEDAR Mitigation Form and email it along with **any supporting evidence** to CEDAR-mitigations@exeter.ac.uk.

For requests that are made due to clinical circumstances (e.g. access to clients) please ask your workplace supervisor/manager/service lead to complete the CEDAR Supplementary Mitigation Form for Clinical Assessments which can act as your supporting evidence. You will be able to attach this completed form to your request.

Please note that mitigation forms must be completed before the deadline or within 24 hours of the deadline passing. Supporting evidence must be uploaded within 10 working days of the assignment deadline at the latest, or the request will not be considered.

Submit this to: CEDAR-mitigations@exeter.ac.uk

Details of Mitigations procedure:

Where necessary (e.g. due to circumstances outside your control) those who require extension on a previously granted mitigation can request a first mitigation of up to 2 weeks.

Please find an outline of the revised process below:

- To request a FIRST mitigation **of up to 2 weeks**: please submit a request form outlining the impact your circumstances are having on your ability to meet a deadline. If the request is on **clinical grounds** you must also submit a supplementary information form from your workplace supervisor.

- To request a SECOND mitigation on the **deferred extension deadline**: please submit a request form (as above) with the relevant deferred extension deadline included. If the request is on **clinical grounds** you must also submit a supplementary information form from your workplace supervisor.

- To request a THIRD/further mitigation: please submit a request form (as above) with the relevant deferred extension deadline included AND an email from your personal / module tutor confirming the request has been discussed. If the request is on **clinical grounds** you must also submit a supplementary information form from your workplace supervisor.

If you are unable to submit by the deferred extension deadline you will need to discuss a further request with your personal / module tutor **before** submitting a mitigation. This is to problem solve issues, signpost support and consider options such as interruption.

Deferred deadlines:
CBT: 1st or 3rd Monday of any month
SFP: 1st or 3rd Thursday of any month
PT: 1st or 3rd Monday of any month
0-5s: 1st or 3rd Wednesday of any month
ASD/LD: 1st or 3rd Thursday of any month.

Download:
CEDAR Mitigation Request Form 2023_4
CEDAR Supplementary Form for Clinical Assessments

Self-Practice, Self-Reflection

Trainees will have the opportunity to engage regularly throughout the course in pre-set self-practice CBT tasks designed to prepare for or deepen learning in the concurrent taught components of the course. Trainees will be invited to complete self-practice, self-reflection tasks linked to specific teaching topics.

See the following reference for further information.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy*, 29, 203-220.

CBT Reading List

Disorder Specific books and publications:

Depression

Brent, D., & Poling, K. (1997). *Cognitive therapy treatment manual for depressed and suicidal youth*. Pittsburgh: Star Centre Publications University of Pittsburgh Medical Centre.

Harrington, R., & Wood, A. (1996) *Cognitive-Behavioural Manual for use with Child Patients with Depressive Disorders*.

IMPACT Trial (2010). A manual for the delivery of CBT in the treatment of young people with depression (unpublished draft).

Martel, C.R., Addis, M.E., & Jacobson N. S. (2001). Depression in Context; Strategies for Guided Action New York: W. W. Norton adapted for adolescents

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral Activation for Depression: A Clinician's Guide*. New York: Guilford Publishers

Ritschel, L.A., Ramirez, C. L., Jones, M., & Craighead, W. E. (2011). Behavioral Activation for Depressed Teens: A Pilot Study. *Cognitive and Behavioral Practice*. 18 281–299.

Verduyn, C., Rogers, J. & Wood, A. (2009). *Depression. Cognitive Behaviour Therapy with Children and Young people*. Hove: Routledge.

McCauley, E., Schloredt, K.A., Gudmundsen, G.R., Martell, C.R., & Dimidjian, S. (2016). *Behavioral Activation with Adolescents*. New York: Guilford Publishers

Generic Anxiety References

Kendall, P. C., & Hedtke, K. A. (2006a). *Cognitive-Behavioural Therapy for Anxious Children: Therapist Manual: Third Edition*. Ardmore: Workbook Publishing.

Kendall, P. C., & Hedtke, K. A. (2006b). *The Coping Cat Workbook: Second Edition.* Ardmore: Workbook Publishing.

Salkovskis, P. M (1996). The cognitive approach to anxiety: Threat beliefs, safety seeking behavior, and the special case of health anxiety and obsessions. In P.M. Salkovskis (ed). *Frontiers of Cognitive Therapy.* New York: Guildford Press.

General Anxiety Disorder (GAD)

Borkovec, T.D., & Sharpless, B. (2004). Generalized Anxiety Disorder: Bringing Cognitive Behavioral Therapy into the Valued Present. In S. Hayes, V. Follette, & M. Linehan (Eds.), *New directions in behavior therapy*. New York: Guilford Press.

Bernstein, D.A., Borkovec, T.D., & Hazlett-Stevens, H. (2000). *New directions in progressive relaxation training: A guidebook for helping professionals.* Westport, CT: Praeger Publishers

Borkovec, T.D. Protocol manuals Combined self-control desensitisation and cognitive therapy manual Applied relaxation and self-control desensitization.

Dugas, M.J., & Robichaud, M. (2007). *Cognitive-behavioral treatment for Generalized Anxiety Disorder: From science to practice.* New York: Routledge.

Obsessive Compulsive Disorder (OCD)

Bolton, D., Williams, T., Perrin, S., Atkinson, L., Gallop, C., Waite, P., & Salkovskis, P. M. (2011). Randomized controlled trial of full and brief cognitive-behaviour therapy and wait-list for paediatric obsessive-compulsive disorder. *Journal of Child Psychology and Psychiatry*, *52* (12), pp. 1269-1278.

March, J. S., & Mulle, K. (1998). *OCD in Children & Adolescents: A Cognitive Behavioral Treatment Manual.* New York: The Guildford Press

Salkovskis, P. M (1999). Understanding and treating obsessive compulsive disorder *Behavior Research and Therapy, 37*, S29-52.

Waite, P. & Williams, T. (2009). *Obsessive Compulsive Disorder. Cognitive Behaviour Therapy with Children and Young people*. Hove: Routledge.

Panic Disorder

Clark, D.M. (1996) Panic Disorder: From Theory to Therapy. In: Salkovskis, P.M. (Ed) *Frontiers of Cognitive Therapy*. New York: The Guilford Press.

Clark, D.M. (1986) A cognitive approach to panic. *Behaviour Research and Therapy*, 24 (4), 461-470.

Clark, D.M. and Salkovskis P.M. (in press) *Panic Disorderin* Hawton, K., Salkovskis, P.M., Kirk, J. & Clark, D.M. (Eds). *Cognitive Behaviour Therapy: A Practical Guide* (2nd Edition). Oxford: Oxford University Press.

Social Anxiety

Clark, D. M. (2001). A cognitive perspective on social phobia. In W. R. Crower. & L. E. Alden (Eds). *International handbook of social anxiety: Concepts, research & interventions relating to the self and shyness.* Chichester: John Wiley & Sons.

Specific Phobias

Kirk, J. & Rouf, R. (2004). Specific Phobias. In J. Bennet-Levy, G.Butler, M. Fennell, A. Hackmann, M. Mueller & D. Westbrook (Eds.), *Oxford Guide to Behavioural Experiments in Cognitive Therapy.* Oxford: Oxford University Press

Ost, L. G. (1989). One session treatment for specific phobias. *Behaviour Research and Therapy, 27,* 1-7.

Post Traumatic Stress Disorder

Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy. 38,* 319-345.

Smith, P., Yule, W., Perrin, S, Tranah, T., Dalgleish, T., & Clark, D.M. (2007). Cognitive behavioural therapy for children and adolescents – a preliminary randomised controlled trial. *Journal of the American Association for Child and Adolescent Psychiatry. 46,* 1051-1061.

Smith, P., Perrin, S., Yule W., & Clark, D. M. (2010). *Post Traumatic Stress Disorder. Cognitive Behaviour Therapy with Children and Young people.* Hove: Routledge.

Separation Anxiety:

Schneider, S., Lavallee, K., (2013). Separation Anxiety Disorder. In Essau, C. A. & Ollendick, T. (Eds). T*he Wiley-Blackwell Handbook of The Treatment of Childhood and Adolescent Anxiety*. Wiley-Blackwell

Schneider, S., Blatter-Meunier, J., Herren, C., Adornetto, C., In-Albon, T., Lavallee, K. (2011). Disorder-specific cognitive-behavioral treatment for Separation Anxiety Disorder in young children: A randomized waitlist-controlled trial. *Psychotherapy and Psychosomatics,* 80, 206-215

Generic Essential CBT Texts

Fuggle, P., Dunsmuir, S., & Curry, V. (2013). *CBT with children, young people and their families*. London: Sage.

Howells, L. (2018). *Cognitive behavioural therapy for adolescents and young adults: An emotion regulation approach.* Oxford: Routledge.

Westbrook, D., Kennerley, H., & Kirk, J. (2007). *An introduction to cognitive behaviour therapy: Skills and applications*. London: Sage.

Additional useful treatment and reference CBT Texts

Albano, A. M., & DiBartolo, P. M. (2007). *Cognitive-Behavioral Therapy for Social Phobia in Adolescents: Therapist Guide: Stand up, Speak out (Treatments That Work)*. New York: Oxford University Press

Bennett-Levy, J., Thwaites, R., Haarhoff, B. & Perry, H. (2015). *Experiencing CBT from the Inside Out: A Self-Practice/Self-Reflection Workbook.* Guildford: Guildford Press.

Bennett-Levy, J., Thwaites, R., Haarhoff, B. & Perry, H. *Reflective practice in cognitive behavioural therapy: The engine of lifelong learning.* http://www.cbttraining.com.au/wp-content/uploads/pdf_publications/Stedmon_Dallos_ch7.pdf

Carr, A. (2000). *What works with children and adolescents? A critical review of psychological interventions for children, adolescents and their families*. London: Brunner-Routeledge.

Chorpita, B. (2007). *Modular Cognitive Behavioral Therapy for Childhood Anxiety Disorders.* Guildford: The Guildford Press.

Farrington, A., & Dalton, L. (2005). *Getting Through Depression with CBT: A Young Person's Guide*. Blue Stallion Publications.

Friedberg, R. D. and McClure, J. M. (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: The nuts and bolts*. Guildford: The Guildford Press.

Graham, P. & Reynolds, S. (2013). *Cognitive Behaviour Therapy for Children and Families* (3rd Ed.). Cambridge: Cambridge University Press.

Greenberger, D., & Padesky, C. (2015). *Mind Over Mood* (2nd Ed.). New York: The Guildford Press.

Greenberger, D., & Padesky, C. (1995). *A Clinician's Guide to Mind Over Mood.* New York: The Guildford Press.

Gurney-Smith, B. (2005). *Getting Through Anxiety with CBT: A Young Person's Guide.* Whitney: Blue Stallion Publications.
Holdaway, C., & Connolly, N. (2005). *Getting Through It with CBT: A Young Persons Guide to Cognitive Behavioural Therapy*. Whitney: Blue Stallion Publications.

Kendall, P. C. (2012). *Child & Adolescent Therapy: Cognitive-Behavioral Procedures.* New York: The Guildford Press.

Leahy, R. & Holland, S. (2012). *Treatment Plans & Interventions for Depressive & Anxiety Disorders*. New York: The Guildford Press

.
Reinecke, M A., Datillio, F. M. and Freeman, A. (Eds) (2003). *Cognitive Therapy for Children and Adolescents: A Case Book for Clinical Practice*. New York: The Guildford Press
Stallard, P. (2002). *Think Good- Feel Good: A cognitive therapy workbook for children and young people.* Chichester:John Wiley & Sons Ltd.

Stallard, P. (2005). A Clinicians Guide to Think Good-Feel Good: Using CBT with children and young people: Using CBT with Children and Young People**.** Chichester: John Wiley & Sons Ltd.

Stallard. P. (2009). *Anxiety. Cognitive Behaviour Therapy with Children and Young people*. Hove: Routledge.

Weisz, J. R. & Kazdin, A. E. (2010). *Evidence-Based Psychotherapies for Children and Adolescents.* New York: Guildford Press.

Useful Websites

British Association of Cognitive Behavioural Therapists
http:www.babcp.com

Choice and Partnership Approach
http://www.camhsnetwork.co.uk

IAPT
http://www.iapt.nhs.uk

Child Outcomes Research Consortium
http://www.corc.uk.net

MindEd
www.minded.org.uk

Young Minds
http://www.youngminds.org.uk

Outcomes, Research & effectiveness
http://www.ucl.ac.uk/CORE

NHS Health and social care bill 2011:
https://www.gov.uk/government/publications/health-and-social-care-bill-2011-combined-impact-assessments

No Health without Mental Health:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

Roth & Pilling (2007) & Roth, Calder & Pilling (NHS Education for Scotland Competence Framework for Workers in CAMHS Settings, 2011):
http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm

Turpin & Wheeler (2011):
http://www.iapt.nhs.uk/silo/files/iapt-supervision-guidance-revised-march-2011.pdf

NICE Guidelines

CG22
National Institute for Health and Clinical Excellence. (2004). *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. Manchester: NICE.

CG113
National Institute for Health and Clinical Excellence. (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care (partial update)*. Manchester: NICE.

CG28

National Institute for Health and Clinical Excellence. (2015). *Depression in children and young people: identification and management in primary, community and secondary care*. Manchester: NICE.

CG31
National Institute for Health and Clinical Excellence. (2005). *Obsessive Compulsive Disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*. Manchester: NICE.

CG 026
National Institute for Health and Clinical Excellence. (2005). *Post-traumatic Stress Disorder: the management of PTSD in adults and children in primary and secondary care*. London: Royal College of Psychiatrists and British Psychological Society.

CG159
National Institute for Health and Clinical Excellence. (2013). *Social Anxiety Disorder: recognition, assessment and treatment*. Manchester: NICE.

CBT Supervision and Clinical Practice Handbook

- **Overview of Supervision and assessment of Clinical Practice**
- **Guidance on use of Supervision**
- **Assessment of Clinical Practice**
- **KSA Trainees**
- **CBT Supervision Reports**

Overview of Supervision and Assessment of Clinical Practice

Supervision and cases

As part of the programme you will receive at least two hours of university-based group supervision a week. This will amount to over 50 hours of group supervision over the course year (please note group supervision hours must be divided by number of practitioners in the group and multiplied by 2 when being logged). You will also receive weekly individual supervision from your workplace supervisor over the year. Over the course of the year you need to have received **70 hours of supervision and 200 hours of supervised CBT practice.**

You will need to see at least eight **completed** cases (seen for 5 sessions or more from start to completion/termination) and have received 5 hours minimum of supervision, **from a supervisor who is a BABCP accredited/accreditable therapist,** on each of these cases. The University will provide the supervision for up to 4 of these cases.

Three of these eight cases must be **closely supervised**. This means in addition to the above criteria, they will also have to have been formally assessed using video or live practice and assessed to be to a reasonable standard as judged by the CTS-R.

Please note that when calculating your supervision hours for the 8 cases all group supervision will be divided by the number of supervisees in the group and then multiplied by two.

We have provided a supervision contract for you and both your supervisors to work through during your initial meetings to help you discuss and agree the nature and content of your supervision. This will form the Supervision Contract between yourself, your University Supervisor and Workplace Supervisor. Please do adapt this to your individual needs if helpful, it is only meant to be a suggested format.

Supervision Feedback

We have provided the BABCP's supervisee feedback form on supervision which can be a useful tool to help you review supervision with your supervisor at the end of each term. At the end of each supervision session we will ask you to provide feedback to your supervisor by using the Helpful Aspects of Supervision Questionnaire (HASQ). This should be reviewed on an ongoing basis with your supervisor and we would encourage you to give accurate and constructive feedback using this tool so that you can gain the most from your supervision sessions over the course of the year.

Your Supervisors

Your University based supervisor will provide you with intensive skills-based supervision, helping to develop your CBT competencies and theory practice links. They will supervise up to 4 cases over the year. The aim is for your University supervision to focus on the 3 closely supervised cases as a minimum. This means you should try to hand in your CTSR competency tapes on the cases that you bring to University supervision.

Your workplace based supervision will also involve caseload supervision. They will hold an overview of all your clinical cases. They will also support you in applying CBT theory and techniques to your cases and will be able to support you in working in your clinical setting and dealing with clinical issues such as risk.

Both your workplace and University based clinical supervisors will be offered training in the requirements of supervision and the clinical assessment associated with the programme. They will also be offered ongoing continued professional development (CPD) and supervision of CBT supervision. It is generally expected that workplace supervisors, as well as being CBT therapists accredited with the BABCP, will also have successfully completed a CYP-IAPT supervisor's course in CBT, or currently be attending one.

Your Role as Supervisee

In addition to filling in the clinical and supervision logs and reports (see below) you will also need to think about your role as a supervisee. This will include coming prepared for your supervision (see supervision preparation form), keeping notes on discussions in supervision

and carrying through jointly agreed action points (see record of supervision) and bringing a summary of your supervision to your 1:1 tutorials (see ongoing summary of supervision hours).You will also be expected to bring weekly video clips of your session with the client. If you have any concerns about your cases or supervision please do raise these with your supervisors in the first instance.
In order to develop a reflective approach to the work you carry out and link theory, practice and supervision, a total of 6 self-rated CTSRs (Log A) should be submitted and three Reflective Practice Logs (Log B).

Guidance on the use of supervision

In order to ensure that you make the most effective use of supervision we suggest you read the guidance included within the supervisors' reports of this handbook. In addition we have included below some suggested content of supervision and supervision methods and topics.

Content of supervision

- Content of supervision will focus on the acquisition of knowledge, conceptualisation and clinical skills within a cognitive behavioural model(s).
- Associated issues will also be discussed when it is relevant to do so e.g. medication, hospitalisation, case management.
- Identification (and collaborative change of these if appropriate) of supervisee thoughts, attitudes, beliefs and values and the impact of these on therapeutic and professional behaviour.
- Discussion and working through relationship and process aspects of supervision.

Supervision methods and topics

- Discussion of therapeutic relationship and engagement issues.
- Case conceptualisation/formulation.
- Rehearsal of therapeutic techniques e.g. simulation, role-play.
- Discussion about therapeutic strategies.
- Case Presentations.
- Homework.
- Review of audio and videotapes*
- Direct observation of practice
- Identification of supervisee thoughts, attitudes, beliefs with exploration of the impact of these on therapeutic and professional behaviour.
- Review of risk and therapist/service user safety.
- Review of clinical guidelines/manuals.
- Review of psychoeducational material.
- Experiential exercises.

- Other strategies as agreed.

*** You will be expected to bring video tapes of your cases to the University on a weekly basis and regularly to your service supervision**.

Assessment of Clinical Practice

At the end of the course each programme member is required to submit a clinical portfolio. This clinical portfolio forms one of the required assessments for module PSYM 301. It also meets the CYP IAPT curriculum requirements. We encourage you to complete the paperwork on an ongoing basis in your portfolio and **you will need to bring these to your termly 1:1 tutorials.**

Please note that we are currently developing a paperless online system for clinical portfolios and we will advise you on this as development progresses.

Supervision Reports
At the end of terms 1 and 2 both supervisors will complete formative supervisor's reports. You will need to submit these to the course on the assessment dates and keep a copy for your records. At the end of term 3 both supervisors will complete summative supervisor's reports, which need to be satisfactorily passed in order for the course to be successfully completed. These also need to be submitted to the course on the assessment date with copies kept for your own records. **It is also required that Term 3 summative supervisor's reports are included within the clinical portfolio – one for the workplace and one for the university supervisor.** If concerns are highlighted in these reports that indicate that the supervisors cannot sign you off as being satisfactory for that stage in your training, an action plan meeting will be arranged between the supervisor and a member of the programme team.

Practice Competency Tapes
You will need to submit 3 therapy tapes over the year (all of which are summative). An appropriate consent form(s) and front sheet should be included. You will also need to submit a CTSR and reflective log when you submit a tape.

KSA Trainees

For those trainees who do not have a core profession, they will need to include their completed KSA portfolio alongside the clinical portfolio at the end of the year (see University KSA Tutor for details of KSA). In preparation for this, please advise your 1:1 tutor each term on how you are progressing with completing your KSA portfolio.

Normally your 1:1 tutor will be a trained KSA assessor –where this is not the case you will have a separate meeting with the KSA tutor to assist you in completing your KSA portfolio.

Forms to download:
KSA Portfolio Checklist
KSA Portfolio Form

CBT Supervision Reports

Formative Reports - Term 1 & 2
At the end of term 1 and 2 trainees need to submit a "Formative University Supervisor Report" and "Formative Workplace Supervisor Report". These reports are reviewed with your university tutor. Where a trainee does not pass their supervisor's reports this will be addressed with the trainee and their tutor and supervisor.

To assist with assessment of your ability to use supervision and your competence, strengths and areas for improvement, the adapted Dreyfus scale (1989), as used with the CTS-R (2001), will be used as a guide to facilitate feedback on competency.

Incompetent - The therapist commits errors and displays poor and unacceptable behaviour, leading to negative therapeutic consequences.

Novice - At this level the therapist displays a rigid adherence to taught rules and is unable to take account of situational factors. He/she is not yet showing any discretionary judgment.

Advanced Beginner - The therapist treats all aspects of the task separately and gives equal importance to them. There is evidence of situational perspective and discretionary judgment.

Competent - The therapist is able to see the tasks linked within a conceptual framework. He/she makes plans within this framework and uses standardised and routinised procedures.

Proficient - The therapist sees the patient's problems holistically, prioritises tasks and is able to make quick decisions. The therapist is clearly skilled and able.

Expert - The therapist no longer uses rules, guidelines or maxims. He/she has deep tacit understanding of the issues and is able to use novel problem-solving techniques. The skills are demonstrated even in the face of difficulties (e.g. excessive avoidance).

Competence level		Examples
Incompetent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced Beginner	2	Evidence of competence, but numerous problems and lacking consistency
Competent	3	Competent, but some problems and/or inconsistencies
Competent	4	Good features, but minor problems and/or inconsistencies
Proficient	5	very good features, minimal problems and/or inconsistencies
Expert	6	Excellent performance, or very good even in the face of patient difficulties

Files to Download:

Formative Supervisor Report

Summative Supervisor Report (University)

Summative Supervisor Report (Workplace)

CBT Resources and Documents

PRECISE Process document
CAPS Precise Scoring Sheet

CBT Supervision Forms

Supervision Contract
Supervisee's Feedback Form
HASQ Form
Record of Supervision Form
CBT Child and Adolescent Practice Scale
Supervision Preparation Form

CBT Clinical Portfolio Forms

Portfolio and Accreditation
Clinical portfolio email signature templates
Clinical Portfolio Document Map
Clinical Portfolio_part 1 (Part 1: Log of Clinical & Supervision Activity)
Clinical Portfolio_supporting document submission
Clinical Portfolio Feedback
Clinical Portfolio Resubmission Form
KSA Portfolio
CBT Teaching Log Cohort 12 Term 1
CBT Teaching Log Cohort 12 Term 2

Other Useful Information:

CAMHs Competency Framework (.pdf)
CBT Competency Framework (.pdf)