# PG CERT Youth Intensive Psychological Practitioner Training

## Trainee Handbook

## Cohort 2

**March 2023**

**Programme Administrator: YIPP@exeter.ac.uk**

**ELE Cohort 2 Page: https://vle.exeter.ac.uk/course/view.php?id=14361**

CEDAR
Clinical Education Development and Research

## Table of Contents

# How to use this handbook

Ensure you have used the course 'Quick Start and How-to Guide' to get up and running for Day 1. This handbook then provides all the detail you need to know about the course, teaching, assessments, submission and relevant policies.

This handbook is split into two parts:

- **Part 1**: Short, quick-access and concise guidance – find the things you need to know quickly and 'at a glance' (pages 1-29).
- **Part 2**: Appendices giving full details, policies, marking schemes etc (pages 30 onwards)

## Supervisor notes

Part 1 outlines the content and assessments of each of the three modules. At the end of each section there are notes for supervisors with guidance on how they can support their trainee(s) not only do well on the course, but to become confident, practised, reflective, evidence-based practitioners. Every supervisor should also have a copy of the 'Supervisor Handbook' which contains the same notes.

## Protection of dignity at work and study

The University of Exeter aims to create a working and learning environment that respects the dignity and rights of all staff and students and where individuals have the opportunity to realise their full potential.

We aim to create an environment and culture in which bullying and harassment are known to be unacceptable and where individuals have the confidence to deal with harassment without fear of ridicule or reprisal.

The University will not tolerate any form of harassment or bullying and is committed to ensuring that staff and students are able to work and study without fear of victimisation.

The University regards any incident of harassment or bullying as a serious matter and will respond promptly and sensitively to formal complaints, and where appropriate take disciplinary action. Additionally, staff and students will be encouraged to resolve concerns informally through a network of trained Dignity and Respect Advisors.

For more information please see: http://www.exeter.ac.uk/staff/equality/dignity/policy/ .

# Part 1 - Quick Reference Guide

## Course contacts

Please contact the programme team at any time with queries by phone or email.

- **Personal tutors** will have up-to-date knowledge of progress and any taught components.
- **The programme administrator** will be able to answer information about course procedures and protocols, e.g. attendance, submission, mitigations etc; and can forward queries to the teaching team

| | |
|---|---|
| **Hannah Sherbersky**<br>YIPP Co- Programme Lead<br>Deputy Director of Post Graduate Taught Programmes and Co-Director of Systemic Portfolio, CEDAR<br>*H.Sherbersky@exeter.ac.uk* |  |
| **Bob Williams**<br>YIPP Co-Programme Lead<br>B.Williams4@exeter.ac.uk |  |
| **Matthew Adam**<br>YIPP Clinical Lead<br>*M.Adam@exeter.ac.uk* |  |
| **Rachel Coles**<br>YIPP Academic Lead<br>*r.coles3@exeter.ac.uk* |  |
| **Rachel Jones**<br>YIPP Academic Tutor<br>r.jones16@exeter.ac.uk |  |
| **Rehma Said**<br>YIPP Academic Tutor<br>rs909@exeter.ac.uk |  |

**Joe Alvis**
Programme Administrator

*YIPP@exeter.ac.uk*

## Communication

For day to day communication, including results notifications, we use trainees' University of Exeter email addresses, so **it is essential that trainees check this address regularly or set up forwarding** to their main email address.

**Trainees: please ensure you use your University email to contact tutors and programme team members,** rather than your service or personal accounts.

# About the team

## Professor Hannah Sherbersky

## Associate Professor and Co-Director of Systemic Programmes
## UKCP Family & Systemic Therapist, RMN, Dip. Creative Supervision
## YIPP Co-Programme Lead

Associate Professor Hannah Sherbersky is a Systemic Family Psychotherapist and Deputy Director of Post Graduate Taught Programmes within Cedar at the University of Exeter. She has many years of experience working within the mental health service; originally as a mental health nurse, then Family Therapist at a regional inpatient unit and now as Co-Director of the Systemic Portfolio and Deputy Director at the University. Here, with colleague Mark Rivett, she has helped to establish one of the most prolific systemic training providers in country. Hannah has developed or co-developed six systemic courses, including systemic supervision, the foundation embedded within the Clinical Doctorate, the family therapy qualifying course, CYP IAPT SFP, family interventions and inpatient training courses. She has co-developed and manualised a model of couple therapy in a research-based couple clinic, and regularly liaises with Health Education England about delivery and commissioning. In 2020 Hannah completed a Doctorate in Clinical Practice, researching notions of 'home' within an inpatient context. She presents nationally and internationally and has published on various family therapy subjects. She is an Associate Editor for the Journal of Family Therapy and is interested in innovative delivery of systemic ideas, recently contributing to a BBC documentary about family therapy (2019), an online couples therapy app (2020) and a UKCP podcast (2020). Hannah is excited by radical approaches to service delivery and systemic leadership; currently collaborating with colleagues in the USA, Belgium and Singapore – and is the Principle Investigator for the new Attachment Base Care research pilot with colleagues from the Attached Based Family Therapy team in Philadelphia due for completion in March 2023.

## Bob Williams

## YIPP Co-Programme Lead

Bob originally trained as a Mental Health Nurse in the mid 1990's and then subsequently as a Family and Systemic Psychotherapist. He has worked in a range of NHS mental health services over the duration of his career, including adult and child, inpatient and community teams. Most recently Bob had been employed by Devon CAMHS to develop and lead the specialist eating disorder service. In addition to his clinical work, Bob has been involved with a range of courses at the University of Exeter, and is currently the Programme Lead for the Family Interventions in Psychosis course, the MSc in Psychological Therapies and the Systemic Supervision course. Bob has published on theme of the 'self of the therapist'.

## Matthew Adam

### YIPP Clinical Lead

Matthew is a qualified Systemic Psychotherapist & Supervisor and registered Social Worker. He worked in Inpatient Child and Adolescent Mental Health services for over 10 years before working as a Commissioner in Child and Adolescent Mental Health Services. He currently works as an independent Psychotherapist in Chester and has a special interest in working with teams and organisations.

## Rachel Coles

### YIPP Academic Lead

Rachel is a Systemic Family Psychotherapist & IAPT Systemic Supervisor. Over the last 18 years Rachel has worked in clinical and management roles within CAMHS, and in other NHS and Children's Services roles. Rachel has a particular interest in eating disorders and attachment. Rachel has a Masters in Clinical Supervision, with an interest in vicarious trauma. Rachel is also the Academic Lead for the Systemic Family Practice CYP-IAPT post graduate diploma.

## Rachel Jones
### YIPP Academic Tutor

Rachel Jones is a Systemic Family Therapist and RMN who has worked for 15 years in NHS child mental health services, both in inpatient units and in the community. Rachel has worked as a clinician and manager in a variety of mental health teams both in the NHS and in private practice and has particular interests in autism, ADHD, eating disorders and emotional dysregulation. Rachel is passionate about meeting young people where they are at, working with systems and ensuring the context is always considered. Rachel is particularly interested in supporting clients using mindfulness.

## Rehma Said
### YIPP Academic Tutor

Rehma is a Systemic Family Psychotherapist, Systemic Supervisor & an accredited Video Interactive Guidance Practitioner (VIG); with experience of working with individuals, couples, families and young people within hospital, school and community settings. Rehma is researcher in issues of cross-cultural practice and ways to increase equity, with a specific interest in and passion for providing therapy to families that is suitable and fits their cultural contexts and backgrounds.

## Joe Alvis
### YIPP Programme Administrator

As Programme Administrator, Joe takes care of all the administrative duties that go on behind the scenes on the course, ensuring that everything runs smoothly and making sure you have all the information to help you on your journey with us. Joe is your first port of call for questions about the course, so if you are unsure on anything, please ask! And always remember, there is no such thing as a silly question.

# Course overview

**The course follows the National Curriculum for YIPP, see** YIPP Curriculum on ELE

**All YIPP training courses, including that of the University of Exeter, follow this national curriculum because it is founded on evidence-based approaches.** Service practises may differ but this national curriculum and the assessment and treatment protocols taught are based on the evidence about what constitutes effective, safe, patient-centred assessment and treatment as part of the IAPT service model and in line with NICE guidelines.

**The programme's aim is to develop the core knowledge and competencies required for YIPPs to safely, effectively, ethically and** inclusively work within a stepped care YIPP service using evidence-based practices, and to continue developing as safe, effective, evidence-based practitioners throughout their careers.

**To achieve this trainees must also be shadowing, observing, practising and working under competent supervision by a fully trained practitioner** within a fully functioning YIPP service.

## The YIPP Programme is part of the University of Exeter's Systemic portfolio.

Our training courses have always been integrative and this is built into the core of many of our programmes. We also wish to privilege two other aspects of family therapy and systemic practice. One is the requirement that family therapy and systemic practice is evidenced-based and evidence-informed. This is a crucial aspect in the contemporary world of NICE guidelines and recommended psychological treatments. Secondly, we wish to privilege the self of the therapist and reflective practice in all our training programmes.

It is our intention that students from all diverse backgrounds and perspectives be well served by our training courses, that students' learning needs be addressed both in and out of teaching sessions, and that the diversity that students bring to this cohort be viewed as a resource, strength and benefit.

We intend to present materials and activities that are respectful of diversity: gender and gender identity, sexuality, disability, age, socioeconomic status, ethnicity, race, and culture. Your suggestions are invited, encouraged, and appreciated.

As a systemic learning community, we aim to create a safe environment that fosters open and honest dialogue for all. We are all expected to contribute to creating a respectful, welcoming, and inclusive environment. To this end, teaching discussions are always conducted in a way that shows respect and dignity to all members of the group. This allows for rigorous intellectual engagement and a deeper learning experience for all.

Systemic Therapy | Clinical Education Development and Research (CEDAR), Psychology | University of Exeter

## Key facts about the course

- **Trainees can take the course at postgraduate level (PGCert).** At PGCert the pass mark is 50%.
- **Trainees must also be shadowing, observing, undertaking in-service clinical skills development and working under competent supervision by a fully trained practitioner** within a fully functioning YIPP service.
- **The course consists of 3 modules, across 45 taught** (teaching theory and clinical skills) **and University directed study days** (directed study, role-play, Self Practice/Self Reflection, problem-based learning etc**). Each module includes assessments.** NB all trainees will need to make additional private study, for example for assessment preparation, exam revision, further reading etc.
- **Teaching locations: All sessions and assessments are being delivered remotely over Zoom**. Remote sessions run from 9.30am – 4.30pm. Zoom links / details for each taught session are detailed on the Timetable found on ELE.
- **ELE:** All timetables, day schedules, course materials and resources are on the course intranet ELE (Exeter Learning Environment) https://vle.exeter.ac.uk/course/view.php?id=14361
  Each trainee has a unique log in to this protected area.
- **Attendance & absence:** Attendance is expected to be 100% in line with national YIPP requirements. All training activity is monitored and logged and regular reports are made to the trainee's service and to the course commissioners. Any absences are noted to the trainee's service. **If any trainee cannot attend or undertake the activities at these times they MUST send an email to the teaching team on YIPP@exeter.ac.uk.** In some cases a 'catch up' option may be agreed, but if this is not possible then an absence will be noted and the trainee's service will be notified. **If a trainee's attendance drops below 80%,** for example through illness or adverse circumstances, **the trainee may not be able to continue training, may not be awarded their qualification or may be required to undertake incomplete modules again.** If illness or unexpected circumstances affect a trainee's ability to engage with the course at the present time, the option of interrupting studies (suspending studies and then resuming at a later date – see Appendix 6) may be available.
- **Timekeeping and attention:** Timekeeping and attention on the programme is expected to be as rigorous as at the workplace. Timekeeping is monitored and any recurrent lapses are notified to the trainee's supervisor. Similarly, trainees' full attention and engagement in the teaching and associated activities is expected, just as in the workplace. Any recurrent lack of engagement will be notified to the service supervisor and may result in ceasing the programme place.
- **Support, study support, accessibility and wellbeing:** All trainees are allocated a personal academic tutor to provide support for personal or service issues that arise and impact a trainee's ability to attend or engage, and as main point of contact for their service supervisor. In addition, all trainees can access the University's study skills support, AccessAbility team, IT support and Wellbeing services - see Appendix 7 for full details. **Trainees who may need an Individual Learning Plan (ILP) to support their learning due to physical or learning needs or other additional needs are advised to contact the AccessAbility team as soon as possible**, preferably prior to starting the course, as there are many adjustments (including extensions to deadlines

and extended examination times) that the teaching team can make, but only where there is a documented ILP in place advising such.

- **Liaison with managers/supervisors/clinical leads:** Academic tutors discuss marks, performance and any difficulties with service supervisors/clinical leads. At the end of Modules 1 and 2 feedback calls to service supervisors are offered to discuss their trainee's course performance to date, give details of upcoming modules/assessments and to offer clarification on any aspect of the course as needed. Service supervisors may contact a trainee's personal tutor or any member of the programme team at any time to discuss course requirements or trainees' needs.
- **Professional practice:** All trainees must always seek to act within the Codes of Practice and Professional Conduct as defined by their service and a professional and/or accreditation body. As such trainees are encouraged to join an appropriate professional body, such as the British Association of Behavioural and Cognitive Psychotherapies or British Psychological Society.
- **Confidentiality:** Trainees must ensure that at all times, when discussing or describing their work and their personal response to their work, that they protect patient, colleague and family and friends' confidentiality by not revealing information that could identify an individual in **any way**. The only exception is if they have concerns relating to the safety of a cohort peer or risk of harm to others. In such exceptions they should discuss with the teaching team to whom information should be disclosed and to what extent. For full guidelines see Appendix 8.

## Course content, assessments and passing or failing the course

- **There are 3 modules**
    - **Module 1 -** Children & Young People's Mental Health Settings: Context and Values
    - **Module 2 -** Working with Young people and their Families with severe and complex mental health needs: Assessment, Engagement and Formulation Skills
    - **Module 3 -** Working with Young people and their Families with severe and complex mental health needs: Therapeutic skills and interventions to improve psychological wellbeing
- **Each module has assessments that must be passed to pass the course. There are also two formative assessments**:
    - **Formative Assessments:**
        1. **360 review** from the team and young people through a team survey and feedback / outcome measures. This would be done half way through training as a formative assessment, which would allow the team to raise strengths and weaknesses for the trainees to work on. This would be followed by a formal sign off of competencies.
        2. **Supervisor report**
    - **Module 1:**

        **Formative**

        1. **Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to working effectively in teams, supporting transitions, working with systems. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families) (Pass/Fail)
        2. **Supervisor Report 1**

        **Summative**

        3. **Group presentation of service related problem-based learning task (eg: on MDT decision or pathway/ transition)1 clinical competency assessment** (assessing the trainees' clinical procedural skills 50%)
        4. **Problem-base learning task write up / reflective analysis (1000 words) 50%**

- **Module 2:**

  Formative

  1. **Discussion of a 360 review** from the team and young people through a team survey and feedback / outcome measures.
  2. **Supervisor report 2**

  Summative

  3. **Podcast/ Vlog:** to demonstrate engagement / therapeutic alliance and include engagement with family. Trainees record a 10/15-minute case presentation and critical analysis of a model or theory (50%)
  4. **Therapeutic formulation letter: to** demonstrate trainee's ability to incorporate a model of formulation within a therapeutic letter to for in relation to a young person and their family that they are working with (50%)
  5. **Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to assessment, engagement, formulation, working in partnership etc. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families) (pass/fail only)

- **Module 3:**

  Formative:

  1. **A video recording or clinical competency simulation**, demonstrating skills in planning and implementing brief interventions to support psychological wellbeing in this context 45min – 60min, with accompanying critical /reflective commentary on your tape (1000 words)

  Summative

1. **A video recording or clinical competency simulation** demonstrating skills in planning and implementing brief interventions to support psychological wellbeing in this context 45 – 60 minutes, with accompanying critical /reflective commentary on your tape (1000 words) (50%)

2. **A written case study** demonstrating skills in assessing, planning and implementing brief interventions to support psychological wellbeing in this context. **3000 words**. (50%)

3. **Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to risk management and interventions with YP and families. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families). **(Pass/Fail)**

4. Clinical Portfolio including supervisor report 3 (0%)

## Clinical Hours

- **Trainees should complete a minimum of 80 clinical contact hours** with young people and their families including within a CYP community mental health service for severe and complex mental health needs and within a CYP inpatient setting as a requirement of their training (of which **40 hours should be specifically delivering intervention / wellbeing support** in line with Module 3 ILOs). Trainees either need to evidence working with cases in both the inpatient and community settings or a case or cases move between the two settings. The clinical practice should encompass three areas:
    - Working with a YP/ Family in the Community,
    - Working with a YP/ Family in Inpatient setting, and
    - Working with a YP/ Family at risk of unnecessary Inpatient Admission (to include crisis).
- **Trainees should undertake a minimum of 40 hours of clinical supervision** of which **at least 20 hours should be case management supervision** and **at least 20 hours should be clinical skills supervision**. Clinical Supervision should be provided weekly by a supervisor who has **extensive experience and expertise in working with children, young people and families who have experienced complex and or severe mental health difficulties**. Ideally, they will also have experience of delivering clinical supervision in their current or recent roles. The particular qualifications or profession of the supervisor is not specified at this stage, but we would anticipate providers to be able to identify supervision personnel based within the team that the YIPP trainee will be operating. There should also be fortnightly individual case management supervision (where the entire caseload is reviewed and actions agreed if there is current high risk, an increase in risk or a regular monthly review of the care plan is due). Case management supervision can be provided by a suitably qualified member of the multi-disciplinary team with competence in the interventions the YIPPs will offer, and who have undertaken training on YIPP supervision. Supervisors should be individuals of a sufficiently senior status within the service with capacity to oversee both case management and how this interacts with the system. Supervision may reduce in regularity as the training proceeds. In addition, there may be a need for particular clinical tasks where specialist supervision will be needed. This will need to be considered within the context of the particular service setting. Supervisors will need to attend the YIPP supervisors training / orientation days at the relevant training provider.
- **To pass the course trainees must pass all the assessments and have a minimum of 80% attendance**. Clinical assessments must be passed with a mark of at least 50% overall and with at least 50% in each of the compulsory pass sections, including risk assessment which is an auto-fail section. Academic assignments must be passed with a mark of at least 50% for the PGCert award. Practice Outcomes Documents for each module must be signed off as competent by in-service supervisors (Pass or Fail).
- **Two attempts for each assessment are allowed**. Second attempts are capped at the pass mark. The overall mark for the module is also capped at the bare pass mark. Failure of a second attempt results in failure of the programme and termination from the course. (See Appendix 4)

- **Failing the course:** Failure of a second attempt at an assessment (less than 50% for clinical assessments or less than 50% for an academic assessment) results in termination from the programme. Under such circumstances training cannot be completed and no academic credit is awarded for any modules with individual assessments failed. (See Appendix 4)

- **Assessment submissions and late or non-submissions:** (See Appendix 4). All work must be submitted on time through the procedures specified and according to the Cohort timetable. Late submissions of first attempts within an hour of the deadline will be docked 5% of the marks. Late submissions (up to 24 hours) are capped at the pass mark; submissions beyond 24 hours are considered non-submissions and therefore score 0 and the whole module is capped at the pass mark. For second attempts there is no 1 hour or 24 hour grace period; submitting beyond the assessment deadline will result in a fail mark being recorded (and also results in a failure of the course). Extensions cannot be granted except by Mitigation. **Any trainee experiencing difficulties with submitting work on time should speak to their personal tutor as soon as possible**.

- **Adverse circumstances, Mitigation and Interruption:** If a trainee is unable to submit an assignment of appropriate quality within the deadline due to short term circumstances beyond their control (e.g. short term illness, difficulties with caseloads etc) they may request Mitigation by submitting a mitigation request via the form on ELE. The Mitigation Committee reviews the request and decides whether to grant mitigation, such as an extension. If a trainee experiences longer term circumstances that impact severely on their ability to engage with the programme it may be possible to Interrupt, i.e. to pause studies and resume them again at a later date. See Appendix 6 for full details. **In all cases trainees and/or supervisors are advised to speak to their course tutor if experiencing difficulties.**

- **Marking turnaround and results:** The turnaround time for marking of academic work is 3 weeks, and 4 weeks for clinical assessments (eg: tape recordings). Results are sent out via email to the trainee's University email account and copied to designated service supervisors. When the work is submitted within two weeks of the start of the summer holidays, the deadline is the later date of EITHER: 15 working days (defined as weekdays which are not designated university holidays) OR the Friday at the end of the first week of the following term

| Assessment Hand-in Schedule | | |
|---|---|---|
| **Module Number** | **Assignment Title / Description** | **Submission Deadline (by 1pm)** |
| 1 /PYCM117 | Summative group presentation | 13th July (slides by 9am) |
| 1 /PYCM117 | Summative project write-up | 28th July |
| 1 /PYCM117 | Formative supervisor's report 1 | 21nd July |
| 2 /PYCM118 | Formative hand in confirmation of the 360 experience | 8th September |
| 2 /PYCM118 | Summative Vlog (previously referred to as Podcast) | 29th September |
| 2 /PYCM118 | Therapeutic Formulation Letter | 27th October |
| 1 /PYCM117 | Formative practice outcome document (POD) A | 17th November |
| 3 /PYCM119 | Formative tape | 24th November |
| 2 /PYCM118 | Formative supervisor's report 2 | 15th December |
| 2 /PYCM118 | Summative practice outcome document (POD) B | 12th January 2024 |
| 3 /PYCM119 | Summative tape & accompanying commentary | 9th February 2024 |
| 3/PYCM119 | Summative written case study | 9h February 2024 |
| 3 /PYCM119 | Summative practice outcome document (POD) C | 1st March 2024 |
| 3 /PYCM119 | Summative clinical portfolio & supervisor's report 3 | 1st March 2024 |

# The role of the clinical supervisor

## Supervision Guidance

### Overview

The Youth Intensive Psychological Practitioner (YIPP) role present an exciting opportunity to grow and enhance the workforce of those working with children, young people and families who have experienced complex and or severe mental health difficulties. As with any new workforce development and training programme, the effective support of trainees to successfully transfer new knowledge and skills into real world practice is a key aspect of successful implementation. As a result, there is an expectation that all YIPP trainees will receive the appropriate supervision as part of their clinical practice.

### Who should be providing Supervision?

As a programme, we fully recognise the workforce challenges present in the system that can result in it being very difficult for services to identify an 'ideal' supervisor. However, this provision of consistent and high-quality supervision is a critical component of the practitioners training; enabling safe and effective practice as they develop their new skills and competencies. It is important for the service to ensure that anyone who is acting as a supervisor for a trainee has **extensive experience and expertise in working with children, young people and families who have experienced complex and or severe mental health difficulties**. Ideally, they will also have experience of delivering clinical supervision in their current or recent roles. The particular qualifications or profession of the supervisor is not specified at this stage, but we would anticipate providers to be able to identify supervision personnel based within the team that the YIPP trainee will be operating. Once identified, it is important for the service to ensure that the supervisor has protected time to support the trainee/s.

### What sort of supervision should be given?

Alongside monthly line management supervision, there are two types of clinical supervision:

1. **Clinical Skills Supervision (CSS)**
2. **Caseload Management Supervision (CMS)**

In **CMS**, the focus should be on discussing risk, changes in presentation, clinical outcomes (e.g., ROMs) and appropriate care-planning (discharge, continued work on clear goals, step up or down to alternative intervention)

Within **CSS**, the focus is on clinical skills delivery and treatment conformity and engage in clinical skills rehearsal with their supervisor, e.g., role-play practice. Clinical skills supervisors are responsible for monitoring supervisees' clinical competences in accordance with the course curriculum outcomes. This requires the supervisee to have demonstrated the clinical skills taught on the programme.

## How often should supervision be given?

YIPP trainees should receive weekly individual case management supervision (between 30mins and one hour depending on caseload size) and fortnightly 1-to-1 or group clinical skills supervision with your service supervisor (2 hours per group of 2-4 supervisees). Case Management supervision can be provided by a senior member of the team who works alongside the trainee as it is recognised that Clinical Supervisors may not be sited in the same service.

All supervisory relationships between a supervisor/supervising team member and a supervisee must have a supervision contract that specifies:

- Location of supervision
- Frequency and length of time per session
- Methods of supervision
- Expectations of supervisee
- Expectations of supervisor
- Escalation processes where required
- Plans for addressing underperformance

## What support and training is available for YIPP supervisors?

As part of knowledge development and implementation support strategy for the YIPP programme, CEDAR will offer a 1-day CPD training in support of the YIPP supervisor development. This will be aimed at the senior staff who will be delivering supervision to the trainee YIPP. **It is strongly encouraged** that attendance is considered by the relevant senior professionals in support of a consistency of knowledge and understanding. Details of the dates, content and booking instructions of the workshops will be made available in due course.

A YIPP Programme Supervisors Induction meeting will be delivered and recorded. All supervisors and Service Leads will be invited to the induction and receive the link to access the recording in order that the information is available and can be disseminated within their services. Monthly supervision meetings will be facilitated by the University of Exeter and will provide a forum to discuss any questions supervisors may have in relation to the content of the programme, the performance of the trainee or to provide support for any workplace dilemmas that might arise including access to the multiple clinical settings that are required for the YIPP programme.

**The role of the trainee's clinical supervisor is paramount** as trainees cannot pass the course without shadowing, observing, practising, and working under competent supervision by a fully trained practitioner within a fully functioning YIPP service.

**A clinical supervisor provides general support but also monitors, develops and assesses the trainee's clinical skills** through a variety of methods. These could include role-play; questioning and answering; direct observation/shadowing of a trainee's assessment and treatment sessions; reviewing taped sessions; reviewing a trainee's patient contact and assessment submissions against the marking schemes; supervising case management supervision; facilitating clinical skills supervision; reviewing trainee reflections and case studies and so on.

**Be aware that when a clinical supervisor signs off a trainee as competent, they are accepting clinical responsibility** for that trainee's competency.

## Specific roles of the clinical supervisor

The below list is not exhaustive, but identifies the key roles and actions of the clinical supervisor:

- **Be familiar with the course structure, timetable, key clinical competencies, assessment dates and marking schemes** and liaise with programme materials and academic staff as much as necessary to fill any gaps in current knowledge.
- **Negotiate, sign and date a supervision contract** clarifying boundaries and responsibilities of the supervisor and supervisee.
- **Facilitate ongoing opportunities and experience for the trainee to develop appropriate competence in clinical skills** across face-to-face (where possible), telephone, group and cCBT modes of delivery (this includes not just YIPP specific assessment and treatment skills but also common factor skills, clinical note taking and record keeping, effective signposting, collaborative care, seeking ad hoc supervision etc). Opportunities may be through role-play or actual patient contact as appropriate to trainees' developing skills.
- **Monitor and adjust trainee's caseloads** to ensure clinical safety and efficacy. This could include pacing or reducing a trainee's caseload so it does not build too rapidly, reallocating away patients with presentations beyond the trainee's current competency, and reallocating to the trainee suitable patients from other YIPP's caseloads or waiting lists so that trainees can develop skills with appropriate patients and meet clinical assessment requirements.
- **Carry out observation of a trainee's work and competence directly and indirectly** - initially through role-play and then through direct shadowing of assessments and treatments, reviewing tapes of sessions, reading and reviewing case notes, trainee referrals etc.
- **Facilitate, monitor and develop trainee skills in case management supervision and clinical skills supervision** in line with YIP national curriculum guidelines.
- **Practice-mark assessment and treatment sessions against the marking schemes**, to identify strengths, weaknesses and the key areas of development needed to meet the required competencies, initially through role-play then through live or recorded sessions.
- **Review and practice-mark treatment formative and summative tapes prior to submission**, identify any shortfalls in development, set objectives for meeting these with the trainee and liaise with academic staff where needed/difficulties are envisaged. Sign (or remote equivalent) cover sheets for live recordings to attest as true recordings of actual patient sessions with patients on the trainees caseload that have been reviewed in case management supervision.
- **Ensure the trainee has opportunity to meet their clinical competencies for each module within the time period of that** module, including the Practice Outcomes Documents which requires allocated supervisor time for review and sign-off prior to the deadline.
- **Where necessary raise issues around a trainee's progress** with appropriate members of staff, both within the service and the University.
- **Make a final decision on whether a trainee has achieved the clinical practice outcomes for each module** and document this in the Practice Outcomes Document within the allocated time periods by signing off as Successful or Unsuccessful.

- **Monitor trainee's accumulation of clinical contact hours and supervision hours** (both clinical skills and case management), ensure records are kept and sign off these as true and accurate.
- **Monitor trainee's accumulation of patient contact and sign off at the end of the course** to state that the trainee has achieved the following (or request an extension if not met):
    - a minimum of **80 clinical contact** hours
    - a minimum of **20 hours of clinical skills supervision**
    - a minimum of **20 hours of case management supervision**
- **Monitor through supervision the trainee's delivery of a complete treatment protocol** with at least one client for each of the following interventions**:**
    - **Working with a YP/ Family in the Community,**
    - **Working with a YP/ Family in Inpatient setting, and**
    - **Working with a YP/ Family at risk of unnecessary Inpatient Admission (to include crisis).**

# Module 1: Children & Young People's Mental Health Settings: Context and Values (20 Credits)

As a YIPP you will provide support and assistance to Clinical Psychologist(s) and the wider MDT in adolescent inpatient units and associated community-based treatment teams. You will provide evidence-based interventions under the direction of your supervisor(s). YIPPSs will operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity. As a YIPP you will need to have a good understanding of your working context and how their role sits within both their local and national systems of care. The YIPPs will learn to demonstrate a commitment to equal opportunities for all and encourage children and young people's active participation in every aspect of care and treatment. You will also demonstrate an understanding and awareness of the power issues in professional / trainee relationships and take steps in your clinical practice to reduce any potential for negative impact this may have. This module will, therefore, expose you to the concept of diversity, inclusion and multi-culturalism and equip you with the necessary knowledge, attitudes and competences to operate in an inclusive values-driven service. As a YIPP you will develop an understanding of your contribution to supporting young people in the context of a collaborating multi-disciplinary team. You will also need to understand the young person and family within the context of the inpatient unit, and start to have an understanding about how the inpatient unit milieu and environment may also be contributing both negatively and positively to the young person's wellbeing.

## Module 1 Aims

1. To equip you as a trainee Practitioner with the necessary knowledge, attitude, and competence to operate effectively in an inclusive, values driven and multidisciplinary service.

2. To equip you as a trainee Practitioner with the necessary understanding of the role of the Clinical Psychologist(s) and the Multi-Disciplinary Team in Inpatient Teams and Home-based Treatment Teams and with the necessary competence to support the work of the Clinical Psychologist(s) under supervision

3. To support you with an understanding of and ability to contribute to team working and to understand how the unit operates as a system.

4. To develop an understanding of and ability to support the therapeutic milieu.

<u>Working with system:</u>

• To understand and learn to work with the family system and social context affecting the child/young person particularly the impact of parental mental illness, parental substance misuse, exposure to domestic violence, transgenerational trauma, and impact of social disadvantage.

• To understand factors relating to resilience in staff and children/young people

• To demonstrate awareness of the neuropsychological aspects of childhood and adolescence (e.g., brain development) and general processes involved in childhood and adolescent development

• To understand the role of advocacy relevant charities and self-help e.g., BEAT, Challenging Behaviour Foundation, Young Minds.

• To evidence knowledge of learning theory and how this links to behavioural management and interventions.

•To evidence knowledge of factors that promote well-being and emotional resilience, (e.g., good physical health, high self-esteem, secure attachment to caregiver, higher levels of social support).

• To demonstrate awareness of normative/non-normative childhood and adolescent behaviour and difficulties across development.

• To demonstrate knowledge of child and adolescent development across physical, neurodevelopment, psychosocial, emotional, cognitive, and moral areas of development.
• To understand the impact of child abuse; neglect, emotional or physical abuse and neglect as well as sexual abuse/exploitation on child/young person's development, relationships, and well-being.

• To understand the Impact of trauma on brain development, attachment, dissociation and possible re-enactment in relationships.

• To evidence the ability to respond to and manage concerns about safeguarding and child protection (in relation to emotional, sexual, and physical abuse and indicators of neglect.
• To understand group processes of patient mix, direct care staff, wider multidisciplinary team and interface with external teams and organization.

Team working:
• Demonstrate an ability to work within the multi-disciplinary team(s) within this context

• Demonstrate an ability to sustain a therapeutic social environment (therapeutic milieu)

• Demonstrate an ability to co-ordinate with other agencies and individuals

• Demonstrate an ability to manage endings Transition, admission, discharge care and liaison with the community MDT – From community to inpatient and back:

• To understand how to develop a relapse prevention plan and an ability to contribute to this in the context of a discharge to community services

• To be able to identify indicators for discharge

• To understand psychological problems associated with discharge

• To understand and contribute to effective and timely pathways to discharge

• To communicate and complete joint planning about discharge plans

• To collaboratively support transfer of care between services (e.g. from community-based treatment to inpatient care and back to community, care support in school).

**Transition, admission, discharge care and liaison with the community MDT – From community to inpatient and back:**

- To understand how to develop a relapse prevention plan and an ability to contribute to this in the context of a discharge to community services
- To be able to identify indicators for discharge
- To understand psychological problems associated with discharge
- To understand and contribute to effective and timely pathways to discharge
- To communicate and complete joint planning about discharge plans
- To collaboratively support transfer of care between services (e.g. from community-based treatment to inpatient care and back to community, care support in school)

## Module 1 Learning objectives

1. Engage and involve children, young people and parents/carers in a way that maximises their collaboration and engagement in mental health services and related settings and contexts including an ability to maintain a professional and reflective relationship in the face of threats to its integrity or challenges to its boundaries.
2. Understand and evidence the core principles of CYP-IAPT, including the use of routine outcome measures and the key principles of core, evidence-based practice / therapies.
3. Support access to Children and Young Peoples' Mental Health Services (CYPMHS) in a way that minimises disadvantage and discrimination.
4. Effectively use self-reflection and supervision to process own emotional responses and enhance clinical work, practicing within level of competence
5. An ability to work from a position that recognises that Children / Young People have human rights and that decisions about their care should balance their safety (and possible restriction) with autonomy, independence and agency in their life with a compassionate and respectful attitude. Holding in mind the risk of the child/young person feeling that they have no choice or control over the ways services intervene, and to address this by conveying a sense that all parties can respect and learn from each other's experience and expertise.
6. An ability to work from a position that assumes that the difficulties experienced and expressed by children/young people can usually be understood in the context of their life experiences, values and background.
7. An ability to work from a position that assumes that helping children/young people (and their families/carers) is best done by developing shared understanding and working collaboratively ensuring that the child/young person and their family/carers experience being understood, and taken seriously.
8. An ability to recognise and value the strengths, resources and assets of the child/young person and their family/carers.
9. An ability for the practitioner to reflect on their beliefs, attributions and assumptions about the factors that contribute to reducing distress and reflect on their reactions to the child/young person, and manage them in a way that delivers compassionate care.

10. An ability to convey a sense of hope and optimism and maintain a style that is likely to be experienced as helpful by being consistently open, responsive and receptive

**Discipline Specific Skills and Knowledge:**

11 Review and evaluate established work and identify some of the strengths and weaknesses of this work

**Personal and Key Transferable/ Employment Skills and Knowledge:**

12 Record accurately interviews and questionnaire assessments using paper and electronic record-keeping systems

13 Evaluate your strengths and weaknesses, challenge received opinion, develop your own criteria and judgement, and seek and make use of feedback

**CONTENT**

- Knowledge of systemic orientation
- CYP services context & principles – local & national
- Service role of the YIPPS & overview of other relevant mental health roles
- Multi agency working & navigation (including context of service delivery)
- Legal/professional issues, (incl. legal framework, ethics, confidentiality, capacity/consent, safeguarding etc.)
- Overview of CYP MH interventions, therapies & evidence base
- Diversity and Culture, social inclusion
- Caseload & clinical management, use of supervision, liaison & clinical decision-making.
- Child, youth and family development and transitions
- Working with families and systems
- Service user involvement
- CYP mental health policy
- Collaborative practice/working and participation
- Reflective practice
- Outcomes-informed practice.
- Multi-disciplinary teamwork in Inpatient Teams and Home-based Treatment teams and working relations between these teams

Module 1 Assessments

- **Module 1:**

**Formative**

1. **Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to working effectively in teams, supporting transitions, working with systems. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families) (Pass/Fail)
2. **Supervisor Report 1**

**Summative**

3. **Group presentation of service related problem-based learning task (eg: on MDT decision or pathway/ transition)1 clinical competency assessment** (assessing the trainees' clinical procedural skills 50%)
4. **Problem-base learning task write up / reflective analysis (1000 words) 50%**

## Module 2: Working with Young people and their Families with severe and complex mental health needs: Assessment, Engagement and Formulation (20 credits)

As a YIPP you will support the assessment of children, young people and families with a range of severe and complex mental health needs in inpatient and community settings as part of a multi-disciplinary team. This assessment must reflect the young person and their family's perspective and must be conducted with the young person's and family's needs paramount. The assessment should reflect a shared understanding of the young person's current difficulties and inform how decisions are made with the family about the best next steps for the young person and the family.

As a YIPP you must be able to undertake a child-centred interview which identifies the child's/ young person's current difficulties, their goals and those of their family/parents, their strengths and resources and any risk to self or others. You will need to understand the young person in the context of their family, culture, wider social environment, developmental stage and temperament. You need to engage the young person and their carer(s) and other family members and to establish and maintain therapeutic alliances. You will need to gather appropriate information from different sources, be able to make sense of this and with the family develop and communicate a shared understanding, and contribute to formulation where appropriate. They also need to understand how the child's difficulties fit within a diagnostic framework, recognize other physical, developmental or psychological difficulties (e.g. epilepsy, autistic spectrum disorders, and attachment history) and know what evidence-based intervention or approaches are likely to be appropriate within the inpatient and community settings.

This module will therefore equip you with a good understanding of the incidence, prevalence and presentation of severe and complex mental health problems experienced by young people in these settings and evidenced-based intervention choices. Skills teaching will develop core competences in active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision-making. The module will develop your competency in assessments including identifying areas of difficulty (including risk) and establish main areas for change, establish and maintain a working therapeutic alliance and engaging the young person/family to support them in recovery, identify and differentiate between common mental health problems in CYP, navigate and use routine outcome measures and standardised assessment tools effectively as part of the assessment and engagement process

## Module 2 Aims

1) To equip you with an understanding of the general developmental needs of YP.
2) To equip you with broad overview of typical mental health presentations, and the aggravating or mitigating circumstances that impact on an admission to an inpatient unit and/or need for crisis care/intensive community support.
3) To equip you with a basic understanding of the risks and benefits of an inpatient admission.
4) To equip you with a broad understanding of the family as a system, and the impact of MH difficulties and service use recursively on the family and the YP.
5) To develop an understanding of how to assess, formulate and review needs of the YP and their family in this context.

6) To develop your understanding of the relational needs of young people and families in these contexts and develop basic skills of engagement and the ability to manage the therapeutic relationship.
7) To support you with an understanding of the importance and active engagement and working in partnership of participation for the YP and family.

## Module 2 Learning objectives and key topics covered

**Key Learning Outcomes:**

- Demonstrate knowledge of childhood and adolescence as developmental stages; the nature, functions thereof and how mental health difficulties might develop in childhood and adolescence. This should include demonstrating knowledge of attachment, attachment disruption and how this can manifest.
- Demonstrate knowledge of common mental health difficulties that might be seen in this context (including self-harm, depression, anxiety, eating disorders)
- Demonstrate an understanding of developmental needs (cognitive, neurodevelopmental etc) and how these might impact on young people and their families in the context of crisis services.
- Demonstrate knowledge of PTSD and complex trauma and how these can manifest and impact on young people and family systems.
- Demonstrate understanding of the nature of inpatient admissions including the risks and benefits.
- Demonstrate understanding of the nature and role of family systems and how they might experience crisis pathways and inpatient admissions.
- Demonstrate skills in building engagement and communication, in developing and maintaining therapeutic relationships with young people and the systems (including families) around them.
- Demonstrate an understanding of risk assessment and management and safeguarding in this context.

**Discipline Specific Skills and Knowledge:**

- Demonstrate skills in assessment in this context (including semi structured interviews, indirect assessment, self-report questionnaires)
- Develop and demonstrate an understanding of the nature, functions, and complexities of formulation as a process, models of formulation and their application in this setting.

**Personal and Key Transferable/ Employment Skills and Knowledge:**

- Make a contribution to models of formulation and their application; demonstrating skills in aiding assessment, interpreting of information, and information sharing formulation in this context.
- Demonstrate the ability to work in partnership with CYP and their parents / carers, drawing on and applying knowledge of co-production and shared decision making in this context.

## Module 2 Assessments

Formative

- **Discussion of a 360 review** from the team and young people through a team survey and feedback / outcome measures.
- **Supervisor report 2**

Summative

- **Podcast/ Vlog**: to demonstrate engagement / therapeutic alliance and include engagement with family. Trainees record a 10/15-minute case presentation and critical analysis of a model or theory (50%)
- **Therapeutic formulation letter:** Client formulation letter. Being able to collaboratively formulate is a key skill in working with children, young people and families in a mental health context. Trainees will be required to produce formulation letter giving a thorough summary of the co-produced formulation. The purpose of this assignment is to assess your ability to effectively formulate in collaboration with young people and families in a way that is understandable and accessible to them, whilst also being able to draw on models of formulation and integrate thinking from the wider team (50%)

Formative:

**Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to assessment, engagement, formulation, working in partnership etc. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families) Pass/Fail only.

# Module 3: Working with Young people and their Families with severe and complex mental health needs: Therapeutic skills and Interventions to improve psychological wellbeing (20 credits)

This module will equip you as a YIPP with a good understanding of and the ability to contribute to the process, under supervision, of therapeutic support and the management of individual young people (and parents / carers) experiencing severe and complex mental health difficulties in inpatient and community settings. As a YIPP you will support the process of a whole team and whole system approach to risk management, developing the ability to assess and manage a range of risk factors and presentations in this context. You will develop an understanding of the application of positive / therapeutic risk management and harm minimizations and be able to identify appropriate actions following risk assessment. You will develop the ability to establish and maintain therapeutic alliances with young people and their parents / carers in this context and interpersonal boundaries that will support therapeutic risk management. You will understand and develop the ability to implement strategies, under supervision, to support active risk management including supporting young people with daily skills and self-care. As a YIPP you will deliver appropriate skills and interventions to improve psychological wellbeing, anxiety and low mood in young people and their parents / carers in this context. You will actively contribute to whole team formulations, behaviour change models and strategies to support emotion regulation and distress tolerance

## Module 3 Aims

1. To equip the trainee with the skills to support psychological intervention under close supervision.
2. To deliver appropriate skills to stabilize and improve psychological wellbeing.
3. To learn brief interventions, which can be delivered (under supervision) from community to inpatient and back.

## Module 3 Learning objectives and key topics covered

**Risk management**

There is an expectation that services will already have the following competences in place and work consistently together using a whole team approach to risk management;

1 Understand the use of relevant code of practice guidelines for children and young people and the least restrictive practice (Refer to Practitioners Handbook for crisis and Inpatient CAMHS). Provide interventions within the least restrictive environment and using least restrictive practice.

2 Recognise the interaction between psychological states and physical risk and implement a framework to reduce use of physical intervention.

3 Use a holistic risk assessment within an agreed framework to develop a risk management plan, including contributing to MDT risk management plans, to mitigate risks such as neglect, self-harm, suicidal intent/acts, absconding/running away, substance misuse, physical aggression, restricted eating/binge/purge, offending behaviour, and risk associated with mobile phones and social media. This will include demonstrating understanding and skills in risk assessment and positive/therapeutic risk management/harm minimization, including involving the parents and family or carer effectively in supporting the young person and in risk management, recognising them as a helpful resource and partner where appropriate.

4 Demonstrate an understanding of the impact of secondary trauma.

5 Understand and contribute to the management of difficult/highly expressed emotions.

6 Establish and maintain therapeutic alliances and set and manage clear interpersonal boundaries.

7 Develop skills in supporting social skills, communication, sleep self-care, daily living skills, self-soothing, relaxation, play, distraction, physical exercise, acceptance, interests.

8 Explore motivation to change and ensure that early changes provide steps for further change and re-evaluation of treatment targets.

**Discipline Specific Skills and Knowledge:**

9 Summarise basic and essential factual and conceptual knowledge of the subject, and demonstrate a critical understanding of this knowledge.

10 Review and evaluate established work and identify some of the strengths and weaknesses of this work.

**Personal and Key Transferable/ Employment Skills and Knowledge:**

11 Record accurately interviews and questionnaire assessments using paper and electronic record-keeping systems

12 Evaluate your strengths and weaknesses, challenge received opinion, develop your own criteria and judgement, and seek and make use of feedback.

## Module 3 Assessments

**A video recording or clinical competency simulation** demonstrating skills in planning and implementing brief interventions to support psychological wellbeing in this context.

Formative:

- **A video recording or clinical competency simulation**, demonstrating skills in planning and implementing brief interventions to support psychological wellbeing in this context **45min – 60minutes, with accompanying critical /reflective commentary** on your tape **(1000 words)**

Summative

- **A video recording or clinical competency simulation** demonstrating skills in planning and implementing brief interventions to support psychological wellbeing in this context **45 – 60 minutes, with accompanying critical /reflective commentary on your tape (1000 words) (50%)**
- **A written case study** demonstrating skills in assessing, planning and implementing brief interventions to support psychological wellbeing in this context. **3000 words. (50%)**
- **Practice Outcome Document (POD):** Trainees will be required to demonstrate competence in the clinical practice outcomes related to risk management and interventions with YP and families. The supervisor will sign off the POD once they are satisfied the trainee has demonstrated competence in all areas. Different sources of evidence can be used to demonstrate completion of each POD competency (direct observation by clinical supervisor, discussion and questioning by the clinical supervisor in supervision, testimony from other colleagues, written case records, use of video recordings of clinical encounters and feedback from your clinical supervisor on these, reflective accounts of how the outcome(s) was achieved, drawing upon the research evidence base and feedback volunteered by YP and families). **(Pass/Fail)**
- Clinical Portfolio including supervisor report 3 **(0%)**

## Further Assessment Information

The assessment of academic and clinical skills is detailed below. All clinical skills should be assessed by practical tests of clinical competence either via live tapes of simulated clinical scenarios. Because of the critical nature of clinical competence, there can be no compensation/condonement for a failed clinical competence assessment. While the assessment strategies for assessing practical clinical skills are set out for each component, the methods of assessing academic skills and knowledge may be varied locally to cover the academic content of all three components.

A service-based portfolio should all cover clinical work in modules 1-3. The portfolio should include details of number of contacts and 'intervention' sessions for each and supervision sessions. Supervisor observation and evaluation / sign off is considered a critical part of the portfolio evaluation process.

## Supervisor helpful notes

1. **Developing, monitoring and managing trainee caseloads**
   Each service has its own policy around when trainees may start assessing patients and how many assessments they may conduct each week. Although trainees acquire theoretical and procedural skills through their University training and role-play practice, the majority of trainees find translating this into effective, real-world clinical practice difficult. To ensure patient safety, adequate clinical standards and staff wellbeing, trainees would benefit from building their assessment caseloads very gradually whilst receiving routine support, observation and immediate supervision for each session until their skills have fully 'bedded down', which may take some weeks. Many trainees find developing their YIPP assessment skills, supervision skills and clinical note taking skills – alongside their University training and assignments - extremely stressful and may need close monitoring and assistance.

2. **Additional role-play**
   Trainees are given role-play opportunities within University taught and study days, but without further role-play opportunities within service will find it difficult to achieve competency. Trainees would benefit from a wide range of role-play partners, including appropriately trained and qualified staff (e.g. recently qualified YIPPs, Senior YIPPs etc). Familiarity with the course requirements, particularly the marking scheme, is highly beneficial for this to be effective. Role-plays can be full or partial, focussing on particular components or skills such as information gathering, risk assessment, information giving, common factors etc.

3. **Marking scheme**
   The University marking scheme for YIPP assessments (Appendix 4) is designed to assess the degree of competency in the key skills needed to engage patients, build the therapeutic relationship and to both get and give the most accurate information with the least room for error. If supervisors would like an update on the marking scheme in order to have a full understanding of what each item is looking for, please contact the trainee's academic tutor. Note that Risk is an auto-fail section, but this is not the only way a trainee may fail. Trainees must gain 50% overall, but they must also be marked as at least competent in Section 2 (information gathering, ROMS, risk), Section 3 (information giving around probable diagnosis, CBT cycle and treatment), Section 4 (shared decision making regarding treatment pathway, mode and intervention planning) and Section 6 (common factors). Failing to do something essential in a compulsory section could result in a fail, as could running out of time.

4. **Questioning skills (Funnelling)**
   Inability to elicit full, relevant symptoms and impacts is a common reason for trainees to fail their competency assessments. For YIPPs to be effective diagnosticians and practitioners, excellent questioning skills are needed so that they are able to quickly, succinctly and fully identify diagnostic symptoms and for differential diagnosis. Trainees need to learn how to start with open questions - in order not to bias or limit what is discussed - and then, once a symptom is indicated, how to move to specific open questions and finally closed questions in order to get full, accurate details. This is called funnelling and is an acquired skill. Additional practice with qualified practitioners on effective questioning, particular around eliciting full details for differential diagnosis and identification of co- or multi-morbidity, is therefore very helpful.

5. **Assessing risk**
   Risk is an auto-fail section, meaning a trainee will fail the whole assessment if they do not conduct a competent risk assessment. The course teaches risk assessment protocols as below

(and see Appendix 9). Service protocols may differ and may include additional checks or information given. Trainees will not be marked down for additional risk gathering or risk information given, but they MUST show at least the minimum.

6. **Information giving**
   Trainees may fail competency assessments on inability to give information well. Providing patients with succinct, easy to follow information about their diagnosis and treatment options is an essential skill for all YIPPs. Trainees should be able to give clear, normalising explanations of common mental health conditions. Trainees must also be able to clearly and succinctly describe what Guided Self Help entails and describe and deliver interventions outlined in module 3 of the handbook.

7. **Timing**
   Failing to complete the competency assessment within time is a common way for trainees to fail. Facilitating trainees to practise full role-plays and learn how to become more efficient, effective and succinct is therefore very beneficial. Trainees may find it helpful to break the assessment down into the distinct sections and attach rough timings to each section to aid this.

8. **Practice Outcomes Document**
   It can take some time to review, discuss and sign this document, so it can be helpful to arrange time for this well in advance of the deadline. Supervisors must review and consider the evidence contained within, combine it with their knowledge of the trainee's practice and decide whether the trainee has or has not fully met each competency. Supervisors signing off trainees as successful are accepting clinical responsibility for the competency of the trainee and as such should only sign if they feel the trainee fully meets the detailed competencies. (See above for how to complete this document.)

# Part 2 - Appendices

# Appendix 1: Timetable, locations and teaching and learning methods

The cohort timetable, available on ELE, details the content and Zoom links for each of the taught days and specifies the number of University directed study days. All remote sessions run from 9.30am to 4.30pm.

## Locations

All sessions and assessments are being delivered remotely.

## Teaching and learning methods

The course is taught across 45 taught days and 20 University Directed Self-Study Days. However additional private study is needed for assignment preparation, revision, further reading etc. Across the course a number of key teaching and learning methods are used following a declarative, procedural, reflective model of learning (Bennet-Levy, 2006).

Together these methods allow the trainee to:

- acquire theoretical understanding of mental health distress and clinical methods of identifying and treating this
- learn techniques and procedures for applying this knowledge effectively in clinical settings in a patient-centred way
- develop effective reflective capacity on their own knowledge, practice and biases as a therapist so they are able to continue developing as a practitioner long after the course has ended

These methods are:

- Lectures
- Small group working/seminars
- Role-play, observation and feedback
- Clinical skills groups
- Guided independent study through University Directed Study Days undertaking a number of independent or peer-group tasks such as reading literature, working through online tutorials and resources, role-playing, self practice/self reflection, reviewing service procedures and policies, etc

In addition, trainees are expected to implement their learning directly into their in-service clinical practice and receive case management and clinical skills supervision in their workplace.

## Self-Practice, Self-Reflection (SP/SR)

**Developing and Enhancing Clinical Competence**

Within the course, key emphasis is placed upon the development of competence across a range of YIPP interventions. A major focus within the University taught days and study days is the trainees' own practice and the rehearsal of the interventions presented during the programme. To help

structure and formalise this component of the programme the Self-Practice, Self-Reflection (SP/SR) model of supervision (Bennett-Levy et al., 2001; Farrand et al., 2010) is adopted.

This model of supervision requires trainees to initially undertake the Low Intensity interventions taught during the course on themselves, and then reflect upon their use. Rather than specifying areas for reflections around each intervention - which can be unnecessarily limiting - trainees are encouraged to provide widespread reflections on anything that arises concerning their self-practice.

All trainees then post their individual reflections on the respective SP/SR blog set up for each intervention. Links to all the blogs are on ELE; each blog is set up with restricted cohort-only access, meaning only members of the teaching team, trainees on the programme and ELE IT support staff can view the posts. The themes from these blogs then form the basis of group clinical supervision sessions as part of University taught days.

# Appendix 2: Passing or failing the course and Appeals

## Passing the course and final awards

Trainees must pass all module assessment to pass a module and all three modules to pass the course. Attendance must be no less than 80%. Final awards are calculated on an average of the module marks. Modules are weighted as follows:

**Module weighting**

- **Module 1: Group Presentation – 50%. Project write-up – 50%**
- **Module 2: Podcast – 50% and Therapeutic Formulation Letter 50%**
- **Module 3: Clinical Assessment (Tape) – 50% , Written Case Study– 50% , plus clinical portfolio (including supervisor's report) and POD C.**

**Final award calculation:**

Final awards are calculated by adding the overall marks from each module and dividing by 3 and are as follows:

**PGCert**

| | |
|---|---|
| **Qualifies for Distinction award** | A final credit-weighted mark greater than or equal to 69.50%<br>or<br>A final credit-weighted mark greater than or equal to 68.00% and modules to the value of at least 50% with a module mark greater than or equal to 70% |
| **Qualifies for Merit award** | A final credit-weighted mark greater than or equal to 59.50%<br>or<br>A final credit-weighted mark greater than or equal to 58.00% and modules to the value of at least 50% with a module mark greater than or equal to 60% |
| **Overall pass mark** | A final credit-weighted mark greater than or equal to 50.00% |

## Receiving certificates

All final marks are ratified by the exam board before certificates can be issued. Once the exam board ratification has occurred, certificates will be sent to the trainee's home address, as recorded on the University of Exeter Student Record System. This process may take 2 – 3 months after final marks are awarded. Trainees should ensure that any changes of address are notified to the University.

## Graduation

As a student of the University of Exeter, all trainees that pass the course will be invited to attend one of the University's graduation days. Trainees will be notified of the dates and invited via email to their University of Exeter email address. Two ceremonies take place a year, one in the summer and one in the winter, however please note

that your graduation ceremony may not be the one closest to the end of your course, so check with the programme administrators before making any advance bookings.

## Failing the course

Trainees must pass all assignments in a module to pass the module, and all three modules to pass the course.

If a trainee fails a first attempt at an assignment, they are allowed a second attempt. If a trainee submits a second attempt at an assessment late, fails to submit or the assignment is marked as a fail (less than 50%), then they fail the whole module and this therefore constitutes a programme fail.

Training ceases and registration on the course is ended. Programme failure may also affect service employment, as most trainee contracts are dependent on completing the course

Trainees should also note that both the Health Education England (HEE), which funds training places for YIPPs, have a national policy of not providing a second training place if a first place fails, so gaining a further YIPP training post in the future is not usually possible in the event of a programme fail.

## Appeals

All students of the University have the right of appeal against academic decisions and recommendations made by the Assessment, Progression and Awarding Committee (APAC) and Faculty Boards (or Deans acting on their behalf) that affect their academic progress.

If considering an appeal, trainees are strongly advised to read the Appeals page on the main University website. Trainees can also contact their academic tutor, the Programme Lead and the Course Administrator for further advice and guidance.

# Appendix 3: Module Descriptors

Module descriptors (PYCM117, PYCM118 and PYCM119) can be found here,
https://cedar.exeter.ac.uk/current/modules/2022_23/

# Appendix 4: Assignment guidance and submission

## Specific assignment guidance

For each assignment detailed guidance is given on ELE. Trainees can refer to ELE and click the appropriate links under each module. Some details are also given in this section of the handbook, below.

## Assignment marking schemes

### Clinical assessment marking schemes

For each clinical assessment there is an associated marking scheme, which is geared towards assessing the clinical competencies necessary for safe, effective, patient-led assessment and treatment.

**The clinical assessment marking schemes and can be found on ELE**. Each marking scheme attempts to track the degree of competency in each of the important elements of an assessment or treatment session. As such they are a highly useful tool to aid trainee development and trainee and supervisor reflections on role play and patient practice. **Also on ELE are interactive marking schemes** where you can click on any section of the marking scheme to view additional notes about that element.

**Please note: for the competency assessments the overall section mark is NOT an average of marks for each element within that section,** but rather a reflection of the overall degree of competency for that section. As such, if a trainee fails to achieve competency in one or more important areas their overall section mark may be below competent (less than 3).

### Academic assessment marking schemes

Academic assessments are marked with consideration given to the following components:

- **Structure and organisation** - trainees are expected to clearly adhere to the required structure for any assignment and for their writing to be clear and accessible with points made being well referenced and linking into clearly understandable arguments/viewpoints which stay strictly focussed on the assignment topic.
- **Knowledge and understanding** - trainees are expected to display a sound breadth and depth of knowledge and understanding of the topic, particularly as it relates to LI working, and the ability to supply relevant and correct information.
- **Theory into practice** - trainees should use literature and the evidence base to support their knowledge, understanding and reflections on their practice.
- **Critical reflection** - trainees should demonstrate the ability to reflect on their discussion and their practice using a critical and evaluative stance taking into account varied standpoints evidenced in the literature base, then to draw conclusions from these reflections.
- **Sourcing** - trainees must demonstrate the depth and breadth of their reading, use a variety of literature to support their writing, show ability evaluate sources and use APA referencing protocols appropriately.

**Marking is numerical against the University-wide marking criteria** for Level 7 (postgraduate level) assessments using the College of Life and Environmental Science (CLES) notched marking scheme, see https://cedar.exeter.ac.uk/iapt/iapt/marking/.

# Mark Sheet for Problem Based Learning Group Project

Programme Member: _____

Module

| | |
|---|---|
| Distinction | □ |
| Merit | □ |
| Pass | □ |
| Fail | □ |

| | Fail (49% and below) | Pass (50-59%) Satisfactory | Merit (60-69%) Good | Distinction (70% and above) Very Good |
|---|---|---|---|---|
| Introduction | □ | □ | □ | □ |
| Context | □ | □ | □ | □ |
| Conceptualisation of the problem | □ | □ | □ | □ |
| Assessment of the problem | □ | □ | □ | □ |
| Dilemmas Arising | □ | □ | □ | □ |
| Self-reflectivity | □ | □ | □ | □ |
| Awareness of professional issues | □ | □ | □ | □ |
| Structure & style of presentation | □ | □ | □ | □ |
| Referencing | □ | □ | □ | □ |
| Spelling/grammar/typos/presentation | □ | □ | □ | □ |

Adhered to time limit (45 minutes) yes / no

**Overall Comments:**

**Feedback for Learning:**

| **Introduction** |
| --- |
| **General comments:**<br><br>**To Improve Further:** |
| **Context** |
| **General comments:**<br><br>**To Improve Further:** |
| **Conceptualisation of the problem** |
| **General comments:**<br><br>**To Improve Further:** |
| **Assessment of the problem** |
| **General comments:**<br><br>**To Improve Further:** |
| **Dilemmas Arising** |
| **General comments:**<br><br>**To Improve Further:** |
| **Self-reflectivity** |
| **General comments:**<br><br>**To Improve Further:** |
| **Awareness of professional issues** |
| **General comments:**<br><br>**To Improve Further:** |
| **Structure and style of presentation** |
| **General comments:**<br><br>**To Improve Further:** |
| **References** |
| **General comments:** |

| |
|---|
| **To Improve Further:** |
| **Spelling, grammar, typos, presentation** |
| **General comments:**<br><br>**To Improve Further:** |

**If you have specific queries about the feedback you have received and would like to arrange a meeting to clarify any learning points, please contact your one-to-one tutor or the academic lead.**

# YIPP Mark Sheet for Reflective Analysis Project

Programme Member: _____

Module

Distinction □

Merit □

Pass □

Fail □

| | Fail (49% and below) | Pass (50-59%) Satisfactory | Merit (60-69%) Good | Distinction (70% and above) Very Good |
|---|---|---|---|---|
| Introduction | □ | □ | □ | □ |
| Use of literature | □ | □ | □ | □ |
| Critique of the PBL/area of focus | □ | □ | □ | □ |
| Critical reflection of the PBL | □ | □ | □ | □ |
| Summary | □ | □ | □ | □ |
| Style and structure | □ | □ | □ | □ |
| Referencing | □ | □ | □ | □ |
| Spelling/grammar/typos/presentation | □ | □ | □ | □ |

**Overall Comments:**

**Feedback for Learning:**

| **Introduction** |
| --- |
| **General comments:**<br><br>**To Improve Further:** |
| **Use of literature** |
| **General comments:**<br><br>**To Improve Further:** |
| **Critique of the PBL idea/area of focus** |
| **General comments:**<br><br>**To Improve Further:** |
| **Critical reflections of the PBL process including group process, using a reflecting model:** |
| **General comments:**<br><br>**To Improve Further:** |
| **Summary** |
| **General comments:**<br><br>**To Improve Further:** |
| **Style & structure** |
| **General comments:**<br><br>**To Improve Further:** |
| **Referencing** |
| **General comments:**<br><br>**To Improve Further:** |
| **Spelling & grammar/typographical errors** |
| **General comments:**<br><br>**To Improve Further:** |

**If you have specific queries about the feedback you have received and would like to arrange a meeting to clarify any learning points, please contact your one-to-one tutor or the academic lead.**

# YIPP Reflective Analysis Marking Guidance 2022

## Reflective Analysis

The 1000 word Reflective Analysis (RA) focuses on critical analysis of both the process of the Problem Based Learning (PBL) group task and of the PBL idea/area of focus chosen. The student will be expected to draw upon relevant theory, research, and literature identified via PBL process. The following areas may be used to inform your structure, considering the weighting of the marking as shown below as a guidance.

N.B.
The pass mark for the Postgraduate (PG) Certificate is 50%. We use notched marking but the table below provides the grade boundaries.

| **1. Introduction: Percentage of marks – 5%**<br>Students should explain the content of the reflective analysis with detail regarding the chosen idea/area of focus for the PBL task. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Excellent presentation of the PBL idea/area of focus chosen with extremely clear information regarding what will be covered in the RA. | Thorough presentation of the PBL idea/area of focus with clear information regarding what will be covered in the RA. | Satisfactory presentation of the PBL idea/area of focus with brief information regarding what will be covered in the RA. | Basic presentation of the PBL idea/area of focus with brief information regarding what will be covered in the RA. | Inadequate presentation of the PBL idea/area of focus with little or no information about what will be covered in the RA. |

| **2. Use of literature to demonstrate understanding of the problem: Percentage of marks - 10%**<br>Relating PBL idea/area of focus to relevant CBT and universal, theory and literature, displaying knowledge and understanding. Relevant theory and literature appropriately applied. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Excellent use of relevant literature (mainly from primary sources). Comprehensive understanding and insightful, clear, accurate account of theories and relevant concepts. Makes excellent theory | Good use of relevant literature. Good, clear understanding of theories and relevant concepts. Makes good theory practice links to the case. | Use of relevant literature or literature not always relevant. Adequate understanding of theories and relevant concepts. Makes adequate theory practice links to the case. | Limited use of literature, not always relevant. Some understanding of theories and relevant concepts. Sometimes makes adequate theory practice links to the case. | Inadequate use of relevant literature. Lack of understanding of theories and relevant concepts. Lack of relevant theory practice links. |

| | | | | |
|---|---|---|---|---|
| practice links to the case. | | | | |

| **3. Critique of PBL idea/area of focus: Percentage of marks - 25%**<br>Critical discussion of PBL idea/area of focus with reference to relevant CBT and universal literature; evidence of collaborative shared decision-making. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Highly appropriate plan. A coherent description of appropriate proposed support interventions. Comprehensive links to literature/evidence-base. Evidence of a highly collaborative approach to shared decision-making. | Appropriate plan. Proposed support interventions described with detail appropriate. Good links to literature/evidence-base. A collaborative approach is clearly evident in relation to shared decision-making. | Satisfactory plan. Adequate description of appropriate proposed support interventions. Links made to literature/evidence-base. Attempts have been made towards collaboration in relation to shared decision-making. | Basic plan. Adequate description of appropriate proposed support interventions. Tentative links made to literature/evidence-base. Some attempts have been made towards collaboration in relation to shared decision-making. | Poor or ill-defined plan. Description of proposed support interventions inadequate or not relevant. Limited links made to literature/evidence base or reference to literature was not relevant. Few or no attempts have been made towards collaboration in relation to shared decision-making. |

| **4. Critical reflection of the PBL process, including group process, using a reflective model: Percentage of marks – 35%**<br>The critical analysis should be balanced, detailing what went well, what was learned from the PBL process, what would be done differently next time, and why. This should include an evaluation of group process during the PBL task. The reflection should be supported by reference to relevant concepts and/or theories and should demonstrate a reflective model such Kolb. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Highly insightful, clear, and accurate evaluation detailing what went well, what was learned from the PBL process, what could be done differently next time, and why. Excellent critical evaluation of strengths and weaknesses of own part in PBL task. Excellent use of concepts and theories to evaluate the PBL process and very effective use of a reflective cycle. Group process issues extremely well considered. | Good, clear, and accurate evaluation detailing what went well, what was learned from the PBL process, what could be done differently next time, and why. Good critical evaluation of strengths and weaknesses of own part in PBL task. Good use of concepts and theories to evaluate the PBL process and effective use of a reflective cycle. Group process issues are well considered. | Clear and accurate evaluation detailing what went well, what was learned from the PBL process, what could be done differently next time, and why. Some critical evaluation of strengths and weaknesses of own part in PBL task. Use is made of concepts and theories to evaluate the PBL process and attempts have been made to use a reflective cycle. Group process issues are given some consideration. | Mostly accurate evaluation detailing what went well, what was learned from the PBL process, what could be done differently next time, and why. Adequate evaluation of strengths and weaknesses of own part in PBL task. Some use is made of concepts and theories to evaluate the PBL process and attempts have been made to use a reflective cycle. Group process issues are given adequate consideration. | Some weakness in evaluation of the PBL process. Inadequate or inaccurate evaluation detailing what went well, what was learned from the session, what could be done differently next time, and why. Mainly descriptive with little or no critical self-appraisal. Little or no attempt at using relevant concepts or theories or those applied are not relevant. No use of reflective model to structure this section. Group process issues are given inadequate consideration. |

| **5. Summary: Percentage of marks - 10%**<br>Conclusion that summarises the content and purpose of the reflective analysis and links to relevant learning from the PBL task. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Clearly and succinctly restates the purpose of the reflective analysis. Expertly summarises the main points. Identifies potential links to further learning or studying for the individual to continue their learning. | Clearly restates the purpose of the reflective analysis. Summarises the main points. Identifies potential links to further learning or studying for the individual to continue their learning. | Restates the purpose of the reflective analysis. Summarises some of the main points. Identifies one or two potential links to further learning or studying. | Draws some conclusions for the purpose of the reflective analysis. Identifies some areas for further learning or studying. | Draws no or very few conclusions for the purpose of the reflective analysis (or they do not logically follow-on from the critical reflection). Does not identify any other areas for further learning or studying. |

| **6. Style and structure: Percentage of marks - 5%**<br>How logical and organised the report is in its presentation, including diagrams and tables if/where appropriate. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **40-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Excellent presentation of report. Highly logical and organised structure with excellent use of sub-headings, diagrams and tables (if appropriate). Excellent use of marking scheme to guide style and | Well-presented report. Logical and organised structure with good use of sub-headings, diagrams and tables (if appropriate). Clear use of marking scheme to guide style and structure of reflection. | Good presentation of report. Mostly logical and organized structure. Use of subheadings, diagrams and tables (if appropriate). Marking scheme mainly used to guide style and structure of reflection. | Satisfactory presentation of report. At times structure was not logical or organised well. Adequate use of subheadings, diagrams and tables (if appropriate). Marking scheme mainly used at times to guide style and structure, | Poorly presented report. Illogical and disorganised structure with lack of use or inappropriate use of relevant subheadings, diagrams and tables. Poor or inadequate use of marking scheme to |

| | | | | |
|---|---|---|---|---|
| structure of reflection. | | | | guide style and structure of reflection. |

| **7. Referencing: Percentage of marks - 5%**<br>All referencing should use consistent referencing APA style. A minimum of five references is expected. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Referencing correct and consistent. All sources are appropriate and primary. Quotations used very appropriately. | Most referencing correct and consistent. Mostly primary sources used. Quotations used appropriately. | Some minor referencing errors and/or same error repeated. Mostly primary sources used. Most quotations used appropriately. | A few inaccuracies in referencing and/or different errors made. Few primary sources used. Too many quotations used. | Gross referencing errors. Evidence of not proof reading. Reliance on secondary or inappropriate sources. Minimum requirement not met. Too many quotations used. |

| **8. Spelling and grammar/typographical errors: Percentage of marks - 5%** | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49<br>G Pass/PG Fail** | **0-39 Fail** |
| Excellent use of English. Grammatically accurate. No typographical errors. | Good use of English. Minimal grammatical and typographical errors. | Clear use of English. Some grammatical errors. Few typographical errors. | Satisfactory use of English. Some grammatical errors. Some typographical errors. | Inadequate use of English. Many grammatical errors. Many typographical errors. |

## Vlog Guidance

The Video Log (Vlog) is a recorded 10-15 minute case presentation and critical analysis of a model or theory. You can record this vlog on a smart phone or iPad and be as creative as you like. You can talk directly to camera and also include film, images and or power point slides if you wish. The Vlog should demonstrate understanding of the concept/skill/idea/modality selected, the application of the concept/skill/idea/modality in the clinical setting and potentially demonstrate engagement and therapeutic alliance building with the young person as well as their family. The following areas may be used to inform your structure, considering the weighting of the marking as shown below as a guidance.

N.B.
The pass mark for the Postgraduate (PG) Certificate is 50%. We use notched marking but the table below provides the grade boundaries.

| **1. Choice of concept/skill/idea/modality- marks – 5%**<br>Students should explain the rationale for their choice of concept, skill, idea or modality, including how it relates to their role as a YIPP. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |
| Excellent presentation of the concept/skill/idea/modality with extremely clear rationale for why this choice was made. Extremely clear understanding of how the concept/skill/idea/modality relates to YIPP role. | Thorough presentation of the concept/skill/idea/modality with clear rationale for the why the choice was made. Clear understanding of how the concept/skill/idea/modality relates to the YIPP role. | Satisfactory presentation of concept/skill/idea/modality with clear rationale for the why the choice was made. Adequate understanding of how the concept/skill/idea/modality relates to the YIPP role. | Basic presentation of the concept/skill/idea/modality- little rationale for why the choice was made. No link made with the concept/skill/idea/modality as it relates to the YIPP role. | Inadequate presentation of the concept/skill/idea/modality with little or no rationale for why the choice was made. No link made with the concept/skill/idea/modality as it relates to the YIPP role. |

| **2. Innovative Presentation: Percentage of marks - 5%**<br>Students should consider how the delivery of the Vlog presentation can be innovative, including different ways of communicating the ideas and content. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |

| | | | | |
|---|---|---|---|---|
| Excellent presentation that includes both verbal and innovative visual styles. Presentation keeps the audience engaged and interested in the content. | Good presentation that includes both verbal and innovative visual styles. Presentation is engaging and interesting. | Presentation includes both verbal and visual styles. Presentation keeps the audience engaged. | Limited presentation does not keep the audience engaged. Recordings provided do not demonstrate therapeutic alliance | Inadequate presentation relying on only verbal presentation. No recordings presented, no demonstration of therapeutic alliance. |

| **3. Demonstrating the link between theory and practice: Percentage of marks - 30%**<br>Students will need to be able to demonstrate both understanding of the theory/concepts being discussed and how it is applied in the clinical setting. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |
| Comprehensive understanding of the concept/skill/idea/modality and why it is effective, including the evidence base for the approach. Excellent link between theory and practice demonstrated through recorded session and presented clearly and coherently. | Good understanding of the concept/skill/idea/modality and why it is effective, including the evidence base for the approach. Good link between theory and practice demonstrated through recorded session and presented clearly and coherently. | Satisfactory understanding of the concept/skill/idea/modality and why it is effective, including the evidence base for the approach. Clear link between theory and practice demonstrated through recorded session and presented coherently. | Poor understanding of the concept/skill/idea/modality and why it is effective. Minimal link between theory and practice inadequately demonstrated through recorded session. | Little understanding of the concept/skill/idea/modality and why it is effective, Inadequate link between theory and practice. |

| **4. Rigour and coherence in presentation: Percentage of marks – 35%**<br>The Vlog should be balanced, detailing what went well, what was learned from the application of the concept/skill/idea/modality to clinical practice and what approaches were taken to establish the therapeutic alliance. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |

| | | | | |
|---|---|---|---|---|
| Highly insightful, clear, and accurate evaluation detailing what went well and what was learned from the application of the concept/skill/idea/modality into practice. Clear understanding of the approach and how young person/family engaged is communicated coherently. | Insightful and accurate evaluation detailing what went well and what was learned from the application of the concept/skill/idea/ modality into practice. Understanding of the approach and how young person/family engaged is communicated coherently. | Accurate evaluation detailing what went well and what was learned from the application of the concept/skill/idea/ modality into practice. Demonstration of understanding of the approach and how young person/family engaged is communicated coherently. | Poor evaluation detailing what went well and what was learned from the application of the concept/skill/idea/modality into practice. Little understanding of the approach and how young person/family engaged. | Inadequate evaluation detailing what went well and what was learned from the application of the concept/skill/idea/modality into practice. No understanding of the approach and how young person/family engaged. |

**5. Limits of the concept/skill/idea/modality including a critical analysis: Percentage of marks - 10%**

Critical reflection on the limitations of the concept/skill/idea/modality and how this limitation may impact upon therapeutic alliance or engagement.

| 70-100 Distinction | 60-69 Merit | 50-59 Pass | 40-49 Fail | 0-39 Fail |
|---|---|---|---|---|
| Clearly and succinctly presents the concept/skill/idea/ modality. Expertly indicates limitations of the concept/skill/idea/ modality and how this impacted upon the therapeutic alliance. Insightful reflection on what could have been done differently. | Clearly presents the concept/skill/idea/ modality. Clearly indicates limitations of the concept/skill/idea/ modality and how this impacted upon the therapeutic alliance. Good reflection on what could have been done differently. | Restates the concept/skill/idea/ modality. Indicates limitations of the concept/skill/idea/ modality and how this impacted upon the therapeutic alliance. Reflection on what could have been done differently. | Draws some conclusions on the limitations of the model. Poor reflection on what could have been done differently. | Draws no or very few conclusions on the limitations of the model. Inadequate reflection on what could have been done differently. |

**6. Addressing or acknowledging power and diversity issues: Percentage of marks - 5%**

Takes into account issues of power and diversity when working with young people and families, acknowledges personal biases and prejudices, provides a reflexive analysis on how power and diversity impact therapeutic alliance.

| 70-100 Distinction | 60-69 Merit | 40-59 Pass | 40-49 Fail | 0-39 Fail |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Excellent overview of power and diversity issues present in case example. Insightful reflections on biases and prejudices. Comprehensive analysis on how therapeutic relationship is impacted by power and diversity issues. | Good overview of power and diversity issues present in case example. Good reflections on biases and prejudices. Good analysis on how therapeutic relationship is impacted by power and diversity issues. | Adequate overview of power and diversity issues present in case example. Clear reflections on biases and prejudices. Adequate analysis on how therapeutic relationship is impacted by power and diversity issues. | Poor overview of power and diversity issues present in case example. Little reflection on biases and prejudices. Little analysis on how therapeutic relationship is impacted by power and diversity issues. | Inadequate overview of power and diversity issues present in case example. Absent reflection on biases and prejudices. No analysis on how therapeutic relationship is impacted by power and diversity issues. |

| **7. Referencing: Percentage of marks - 5%**<br>All referencing should use consistent referencing APA style. A minimum of five references is expected. | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |
| Referencing correct and consistent. All sources are appropriate and primary. Quotations used very appropriately. | Most referencing correct and consistent. Mostly primary sources used. Quotations used appropriately. | Some minor referencing errors and/or same error repeated. Mostly primary sources used. Most quotations used appropriately. | A few inaccuracies in referencing and/or different errors made. Few primary sources used. Too many quotations used. | Gross referencing errors. Evidence of not proof reading. Reliance on secondary or inappropriate sources. Minimum requirement not met. Too many quotations used. |

| **8. Spelling and grammar/typographical errors: Percentage of marks - 5%** | | | | |
|---|---|---|---|---|
| **70-100 Distinction** | **60-69 Merit** | **50-59 Pass** | **40-49 Fail** | **0-39 Fail** |
| Excellent use of English. Grammatically accurate. No typographical errors. | Good use of English. Minimal grammatical and typographical errors. | Clear use of English. Some grammatical errors. Few typographical errors. | Satisfactory use of English. Some grammatical errors. Some typographical errors. | Inadequate use of English. Many grammatical errors. Many typographical errors. |

## Guidance for writing the 'client formulation letter'.

**Assignment purpose**

Being able to collaboratively formulate is a key skill in working with children, young people and families in a mental health context. The purpose of this assignment is to assess your ability to effectively formulate in collaboration with young people and families in a way that is understandable and accessible to them, whilst also being able to draw on models of formulation and integrate thinking from the wider team.

**Assignment description**

Write a letter to a young person, which may include their family, giving a thorough summary of the formulation you have collaboratively developed with the young person/family and the wider team.

This should be a real young person from your caseload, and therefore consent needs to be acquired, and confidentiality rules adhered to.

**Considerations when writing the letter:**

The letter will need to be written directly to the client, not professionals. However, think about who you are writing the letter to. Is it the young person individually, or to other family members as well? Whichever you chose there needs to be a rationale for this. Who are you going to copy the letter to (other professionals, family etc) and why? How will you explain this to the recipient(s)?

The letter needs to show that you are working collaboratively. Developing a shared understanding of the presenting difficulty with young people and families is key to engagement and successful therapeutic outcome, so be thoughtful about how you achieve this. Be mindful of your language and try to make your writing accessible to the recipient, this is primarily a client letter not a communication to professionals.

The letter needs to demonstrate that you have a good working knowledge of common mental health difficulties in young people.

The letter needs to demonstrate that you are being guided by one of the formulation models you have been introduced to on the course. You will need to demonstrate that you are including wider contexts in the formulation such as developmental stage, family history, life events, diversity, culture power and oppression etc.

Be mindful and inclusive of contributions to the formulation from other professionals and team members. You should also consider referring to the use of ROMs or structured assessment tools.

You will need to demonstrate that you have considered risk.

Finally, this is a course assignment and therefore it is not a requirement that you actually send the letter to the young person or family that you are working with. However, you and your supervisor/team may consider this appropriate, and you may want to use this in your clinical work.

## Client formulation Letter marking guidelines

| **1. Introduction and setting the context for the letter - 10%** | | | |
|---|---|---|---|
| Trainee gives a rationale for the letter and sets the context, including why a shared formulation is important. Trainee will clearly give rational for including/excluding recipients (both client and professional). | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |
| **2. Ability to effectively construct a formulation - 25%** | | | |
| Trainee demonstrates being able to present complicated information in a coherent way, drawing from at least one formulation model, and effectively integrating contextual factors such as developmental stage, family context, life experiences, diversity, culture, power and oppression. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Trainee demonstrates excellent formulation skills, integrating a wide range of contextual factors and clearly drawing from a formulation model. | Trainee demonstrates good formulation skills, integrating a range of contextual factors and evidences drawing from a formulation model. | Trainee demonstrates adequate formulation skills, integrating some contextual factors and shows some evidence of drawing from a formulation model. | Little to no evidence of effective formulation skills. Little evidence of the consideration of context, and little to no evidence of the use of a formulation model. |
| **3. Knowledge of common mental health presentations in young people, including assessment of these presentations - 25%** | | | |
| Trainee demonstrates a good working knowledge of common mental health presentations in young people. This may include etiology, symptom profile, risk, prognosis etc. Trainee will demonstrate understanding of ROMs, assessment tools, wider team assessment. A key part of this is to demonstrate how this knowledge links with the previous section on effective formulation. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |
| **4. Shared decision making and collaboration - 25%** | | | |
| Developing a shared understanding of the presenting difficulty with young people and families is key in engagement and successful therapeutic outcome. Trainee demonstrates that they have engaged collaboratively with young people and families and that the ideas presented in the formulation are co-produced. If elements of the formulation come solely from wider team members, the trainee will demonstrate the thought given to how this information is presented. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |
| **5. Structure and writing style - 15%** | | | |
| The letter needs to have a clear structure and coherence to it. The trainee will demonstrate writing in a style that demonstrates an ability to make complex information accessible to the reader. This will include the appropriate use of language. The trainee will avoid the use of unnecessary jargon, and be careful with spelling, grammar and overall presentation. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |

## Client formulation letter (Marksheet)

☐ Formative

☐ Summative

**Programme Member:**

☐

Distinction

Merit ☐

Pass ☐

Fail ☐

Overall comments:

| Weighting | Section | Distinction 70% + | Merit 60 – 69% | Pass 50 – 59% | Fail 49% or below |
|---|---|---|---|---|---|
| 10% | Introduction and setting the context | ☐ | ☐ | ☐ | ☐ |
| 25% | Ability to effectively construct a formulation | ☐ | ☐ | ☐ | ☐ |
| 25% | Knowledge of common mental health presentations in young people, including assessment of these presentations | ☐ | ☐ | ☐ | ☐ |
| 25% | Shared decision making and collaboration | ☐ | ☐ | ☐ | ☐ |
| 15% | Structure and writing style | ☐ | ☐ | ☐ | ☐ |

| Introduction and setting the context for the letter |
| --- |
| **General Comments:**<br><br>**To Improve Further:** |
| **Ability to effectively construct a formulation** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Knowledge of common mental health presentations in young people, including assessment of these presentations** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Shared decision making and collaboration** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Structure and writing style** |
| **General Comments:**<br><br>**To Improve Further:** |

If you are unclear on any feedback received, please do make an appointment to meet with your personal tutor to discuss this.

## Criteria for Vlog Project

Programme Member: _____

Module

Distinction □

Merit □

Pass □

Fail □

| | Fail (49% and below) | Pass (50-59%) Satisfactory | Merit (60-69%) Good | Distinction (70% and above) Very Good |
|---|---|---|---|---|
| Choice of concept/skill/idea/modality | □ | □ | □ | □ |
| Innovative presentation | □ | □ | □ | □ |
| Demonstrate link btw theory/practice | □ | □ | □ | □ |
| Rigour & coherence | □ | □ | □ | □ |
| Limits of concept/skill/idea | □ | □ | □ | □ |
| Addressing power & diversity | □ | □ | □ | □ |
| Referencing | □ | □ | □ | □ |
| Spelling/grammar/typos/presentation | □ | □ | □ | □ |

**Overall Comments:**

**Feedback for Learning:**

| **Choice of concept/skill/idea/modality** |
|---|
| **General comments:**<br><br>**To Improve Further:** |
| **Innovative presentation** |
| **General comments:**<br><br>**To Improve Further:** |
| **Demonstrate link btw theory/practice** |
| **General comments:**<br><br>**To Improve Further:** |
| **Rigour & coherence** |
| **General comments:**<br><br>**To Improve Further:** |
| **Limits of concept/skill/idea** |
| **General comments:**<br><br>**To Improve Further:** |
| **Addressing power & diversity** |
| **General comments:**<br><br>**To Improve Further:** |
| **Referencing** |
| **General comments:**<br><br>**To Improve Further:** |
| **Spelling & grammar/typographical errors** |
| **General comments:**<br><br>**To Improve Further:** |

**If you have specific queries about the feedback you have received and would like to arrange a meeting to clarify any learning points, please contact your one-to-one tutor or the academic lead.**

**YIPP 2022**

**Formative and Summative Tape Guidance**

You are required to submit two tapes as part of the competency assessment process for the YIPP programme. One tape is formative, due 25th November 2022, the second tape is summative and due on 10th February 2023.

The tape will need to be a minimum of 45 minutes and maximum of 1 hour, demonstrating a therapeutic session of you working with a young person either alone, or with their family. Please note, all participants in the taped session are required to sign the consent form, which must be included in the submission to the University of Exeter. The tape needs to include and demonstrate:

- **An introduction to the session:**

(Trainee greets client and orients to the session, defines a timescale for the session, obtains consent to record, collaboratively sets agenda for session/outlines purpose of the session, reviews the previous session, and review task based practice with the YP/family)

- **A demonstration of Interpersonal skills including:**

Displaying authentic warmth and empathy through verbal communication skills; displaying engagement by non-verbal cues; demonstrating non-judgmental/non-blaming approach and unconditional positive regard; acknowledging the problem by reflecting and summarising; modelling elements of evidence based approach (e.g. use of specific praise or problem-solving); encourages and reinforces any progress the client is making; considered use of developmentally appropriate language and engagement techniques; allowing client opportunity to query/ask questions about suggested strategies (i.e. collaborative approach throughout rather than didactic.

- **Information gathering and shared understanding:**

Identifies with the client and or family what the main problems have been and ascertains whether there have been any change since last contact using ROMs in a meaningful way. Explores behavioural, cognitive and emotional aspects of the problem when appropriate and makes reference to theoretical or intervention model to make shared sense of the client's experience. Uses client-centred interviewing and clear information gathering; uses a funneling approach to elicit (new or existing) client-centred problem identification by: (a) general open questions, (b) specific open question, (c) summarising and clarification, and (d) closed questions. Elicits regular feedback from client (as well as giving feedback as above), for example checking understanding and allowing opportunities for client to give feedback.

- **Shared decision making and collaboration:**

Facilitates effective teamwork with the client; demonstrates working towards shared goals (including reviewing of treatment goals). Explores any difficulties/barriers (this may be in relation to task-based work tasks or linked to next steps in intervention); clear and collaborative action plan is put in place and clear method of implementation and recording of action plan (e.g. diaries or record sheets).

- **Intervention**

Trainee provides a clear rationale for the intervention that is understood by client and trainee; checks with client that s/he still wishes to continue with the treatment plan e.g. after presenting a rationale 'do you think that's something that could be helpful?', 'are you happy if we go ahead and start that

today?' ; demonstrates an appropriate evidence-based approach; delivers an appropriate intervention for the stage of treatment; demonstrates working effectively with clients' parents in the room where appropriate; uses appropriate resources, worksheets, materials etc. Motivates/encourages client to engage in strategies and practice strategies in session (where appropriate).

- **Session structure and ending:**

Structures session with a clear beginning, middle and end and is paced appropriately; summarises the session at the end; collaboratively agrees task-based practice that is clearly linked to the content of the session; rationale for task-based practice is understood and agreed by client; obtains feedback from client on session (e.g. SRS); agrees next appointment.

**An important note regarding risk**

AUTOFAIL: It is not expected that a full risk assessment will be conducted in every treatment session unless indicated at assessment. However it is good practice to ask clients whether there is any change to their risk / safety since last session.

If a risk assessment is indicated (e.g. client expressed hopelessness, deterioration in mood) and not conducted, or is indicated but then conducted in an inappropriate manner (e.g. not in line with safeguarding processes and/or the thorough risk assessment teaching received at the University), the recording will be deemed an auto fail, even if all other assessment domains are of pass standard.

NB: If the presence of risk is indicated (in relation to risk to/from themselves), this will require the trainee to go beyond solely covering the elements of the risk assessment list (risk to self, to others, from others, neglect). For example, as part of a risk management strategy, the trainee will need to ensure that the client is safe, to agree a plan with the client about whether any information needs sharing beyond this session (in particular gaining consent to share information with parents/carers if appropriate), create a safety plan if indicated and to give him/her clear instructions about how to make contact with the service (or other relevant services) in the event of a crisis situation.

Further information regarding the marking boundaries for different grades can be found on ELE.

**YIPP - 2022**

**Formative Tape Role Play Guidance for Trainee and Supervisors**

It is recognised that the resources required to undertake the Formative Taped assignment may not be in place in time for the YIPP trainee to gain consent from the young person and/or family to participate in a recorded session. Therefore, in order to provide some flexibility for the Formative Tape assignment a standardised role play will be permitted: The role play must be well considered and robust so that the trainee is able to demonstrate their capabilities in each of the identified sections in the attached guidance:

The tape will need to be a minimum of 45 minutes and maximum of 1 hour, demonstrating a therapeutic session of the trainee working with a young person either alone, or with their family. This needs to include:

1. The role play must involve a 'young person' with a presenting problem. It is suggested that this 'young person' is developed as a character so that the simulation is as smooth and accurate as possible to a 'live' session. Character development should include:
    a. Family of Origin information, e.g. siblings, parental marital status, extended family, history of mental health/illness/family dynamics
    b. Age of the young person, year in school, experience of peer groups
    c. Experiences leading to the development of the problem including physical health, neurodevelopmental conditions if any, etc.
    d. Development of the problem and symptoms as presented
    e. Mental state of the young person
    f. A realistic representation of the existing cohort, e.g. capacity to engage/work with the trainee

2. The development of the role play should be undertaken by both the Case management Supervisor and the Clinical Supervisor. The simulation must be as realistic as possible to a live session and therefore all relevant aspects of the individual that may be identified or discussed in formulation meetings or clinical assessments should be written into the development of the character.

3. The Clinical Supervisor, Case Management Supervisor or both must be involved in the role play, though including additional staff members to constitute the 'family' is encouraged. All participants in the role play will need to complete a consent form, which must be included in the submission of the tape to the University of Exeter.

4. Where it has been deemed important to include additional 'family members' in the simulation, careful attention should be given to how the 'young person' and the 'family' should interact. This should be as close to 'real life' as possible, though participants should

neither overact or underact the roles as this will impact how the trainee responds in the simulation. This may negatively affect the simulation and the trainee's capacity to enact a genuine stance.

5. The role play must represent real life as best as possible. If the trainee is simulating a first session they should be given preliminary information similar to referrals that your service receives, enabling them to undertake information gathering and to begin to formulate.

6. If the trainee is simulating a second or third session, this will be apparent at the introduction of the session. The trainee must experience this as though it were a live session and therefore the trainee must not have any prior awareness of how the 'young person' or 'family' have experienced the time between sessions.

7. If the role play is to include an exploration of risk leading to risk management or care planning approaches, it is advised that this is discussed with all participants in the role play, other than the trainee, to ensure that the issues and concerns are clear and that they are thoroughly explored by the trainee.

8. The role play should commence and end with all participants 'in-role'.

9. The trainee should be given the opportunity to lead the session and therefore participants of the role play should not overshare information in a way that would not be seen naturally in a live session.

10. The simulated session will be marked against the same marking criteria as a live taped session. Please see the attached marking criteria to consolidate understanding about what skills the YIPP trainee needs to demonstrate in the recording.

**(PG) - YIPP Session Recording Marking Criteria**

| **1. Introduction to the Session - 10%** | | | |
|---|---|---|---|
| Trainee greets client/family and orients to the session, defines a timescale for the session, obtains verbal consent to record, collaboratively sets agenda for session/outlines purpose of the session, reviews the previous session, and reviews task-based practice with the client/family. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard, e.g. trainee greets client/family very appropriately, defines a clear time scale for the session, sets a highly collaborative agenda, reviews the previous session in a meaningful way, and reviews task-based practice appropriately (whether client/family has completed on not). | Almost all of the criteria above are met to a good standard. For example, the trainee greets client/family, includes a timescale, sets an agenda with attempts at collaboration, reviews the previous session, and conducts a review of task-based practice. | Most of the above criteria are met to a satisfactory degree. For example, the trainee may greet client/family, loosely define a timescale (e.g. "we've got the usual time available"), set a rough agenda or set an agenda didactically. Review of previous session / task-based practice may be unclear or vague, or conducted in a way that has little meaning or value for the client/family. | Most of the above criteria are not fully met. For example, on greeting the client/family the trainee may be overly colloquial or too brusque and didactic, they may fail to define a timescale or agenda, set a rough agenda and conduct a vague review of task-based practice (or does not appropriately address task-based work non-compliance). |

| **2. Interpersonal Skills - 25%** | | | |
|---|---|---|---|
| Interpersonal skills include the following: displaying authentic warmth and empathy through verbal communication skills; displaying engagement by non-verbal cues; demonstrating non-judgmental/non-blaming approach and unconditional positive regard; acknowledging the problem by reflecting and summarising; modelling elements of evidence based approach (e.g. use of specific praise or problem-solving); encourages and reinforces any progress the client/family is making; considered use of developmentally appropriate language and engagement techniques; allowing client/family opportunity to query/ask questions about suggested strategies (i.e. collaborative approach throughout rather than didactic). | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Trainee displays excellent interpersonal skills with clear evidence of empathy and engagement. Is able to accurately summarise and reflect upon the client/family's presenting problem in a meaningful way, encourages progress, and skillfully uses developmentally appropriate language and engagement techniques. There is evidence of a highly collaborative approach. | Trainee displays good interpersonal skills and is able to summarise the problem and engage in some reflection. Some evidence of using developmentally appropriate language and engagement techniques. Provides some encouragement of progress, and displays good empathy through verbal and non-verbal behaviours. There is evidence of a collaborative approach. | Trainee displays some empathy and engagement and is able to summarise the problem and reflect with the client/family reasonably accurately. There may be limited evidence of encouraging the client/family's progress or using age- appropriate language. There are some attempts at collaboration. | Little to no evidence of empathy or engagement. Poor eye contact and minimal reflection of problem back to the client/family. Little encouragement seen. Assumptions are made about client/family perspective without checking with him/her first. Little or no evidence of a collaborative approach. Use of language or engagement techniques inappropriate to the client/family's developmental stage. |

| **3. Information gathering and shared understanding - 20%** | | | |
|---|---|---|---|
| Identifies or reminds client/family about the main problem statement agreed at the last contact and ascertains whether there have been any change since last contact, using ROMs in a meaningful way if appropriate. Explores behavioural, cognitive and emotional aspects of the problem when appropriate and makes reference to theoretical or intervention model to make shared sense of the client/family's experience. Uses client/family-centered interviewing and clear information gathering; uses a funneling approach to elicit (new or existing) client/family-centered problem identification by: (a) general open questions, (b) specific open question, (c) summarising and clarification, and (d) closed questions. Elicits regular feedback from client/family (as well as giving feedback as above), for example checking understanding and allowing opportunities for client/family to give feedback. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Trainee meets all of the criteria outlined above including highly appropriate use of ROMs. Trainee demonstrates excellent understanding of the theoretical / intervention model and incorporates this in to the session very well to promote a clear, shared understanding. Trainee demonstrates highly appropriate questioning and information-gathering techniques to develop shared understanding. | Trainee meets almost all of the criteria above including appropriate use of ROMs. Trainee demonstrates clear understanding of the theoretical / intervention model and incorporates this in to the session in a manner relevant to the client/family. Trainee demonstrates appropriate questioning and information-gathering techniques to develop shared understanding. | Trainee meets an adequate amount (at least 50%) of the criteria above including appropriate use of ROMs. Trainee demonstrates a basic understanding of the theoretical / intervention model and incorporates this in to the session. Client/family understanding of the relevance of the model may be unclear at times. Trainee generally uses questioning and information-gathering techniques satisfactorily. | Trainee fails to meet many (i.e. more than 50%) of the criteria above. Trainee demonstrates a poor or inconsistent understanding of the theoretical / intervention model and there is little attempt to incorporate it in to the session. Client/family understanding of the relevance of the model is unclear or missing. Questioning and information-gathering techniques are inadequate, irrelevant or inappropriate and fail to develop a shared understanding. |

| **4. Shared decision making and collaboration - 10%** | | | |
|---|---|---|---|
| Facilitates effective teamwork with the client/family; demonstrates working towards shared goals (including reviewing of treatment goals). Explores any difficulties/barriers (this may be in relation to task-based work tasks or linked to next steps in intervention); clear and collaborative action plan is put in place and clear method of implementation and recording of action plan (e.g. diaries or record sheets). | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Trainee meets all of the criteria above to a high standard. Skilfully facilitates effective teamwork, clearly demonstrates collaborative working towards shared goals, collaboratively problem solves barriers effectively. | Trainee meets almost all of the criteria above to a good standard. For example, the trainee may facilitate effective teamwork and demonstrate working towards shared goals, with some effective collaboration evident. | Trainee adequately meets most of the criteria above. For example, the trainee facilitates some teamwork, and makes attempts at collaborative working towards shared goals. | Trainee fails to facilitate effective teamwork (or does so to a limited extent), or shows very limited working towards shared goals. |

| **5. Intervention - 25%** | | | |
|---|---|---|---|
| Trainee provides a clear rationale for the intervention that is understood by client/family and trainee; checks with client/family that s/he still wishes to continue with the treatment plan e.g. after presenting a rationale 'do you think that's something that could be helpful?', 'are you happy if we go ahead and start that today?' ; demonstrates an appropriate evidence-based approach; delivers an appropriate intervention for the stage of treatment; demonstrates working effectively with client/family in the room where appropriate; uses appropriate resources, worksheets, materials etc. Motivates/encourages client/family to engage in strategies and practice strategies in session (where appropriate). | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Trainee provides a very clear rationale for the intervention and effectively checks client/family understanding. Checks consent to continue with the treatment plan. Excellent, skillful demonstration of a highly appropriate evidence-based approach with excellent use of appropriate materials. Highly skillful engagement of the client/family in utilising strategies. Demonstrates highly appropriate and effective work with client/family in the room where appropriate. | Trainee provides a clear rationale for the intervention and checks client/family understanding. Checks consent to continue with the treatment plan. Good demonstration of an appropriate evidence-based approach with good use of appropriate materials, and skillful engagement of the client/family in using the strategies. Demonstrates working with client/family where appropriate, for example if the client/family indicates parental involvement in an exposure hierarchy would be helpful. | Trainee provides a satisfactory rationale for the intervention and seeks some consent from the client/family to try the intervention. An evidence-based approach appropriate to the presenting problem, client/family goals and stage of treatment is utilised with satisfactory competence. Engagement of parents, where applicable, is generally appropriate. | Trainee fails to utilise an evidence-based intervention appropriate to the presenting problem or stage of treatment. Fails to provide a clear rationale, or to engage the client/family in strategies discussed. |

| **6. Session Structure and Ending- 10%** | | | |
|---|---|---|---|
| Structures session with a clear beginning, middle and end and is paced appropriately; summarises the session at the end; collaboratively agrees task-based practice that is clearly linked to the content of the session; rationale for task-based practice is understood and agreed by client/family; obtains feedback from client/family on session (e.g. SRS); agrees next appointment. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| Session is extremely well-structured and paced appropriately. Trainee provides a clear and comprehensive summary of the session and agrees highly appropriate task-based practice that logically follows on from the session in a highly collaborative way. Ensures that the client/family understands the rationale for the task-based practice. Feedback is sought skillfully | Session is well-structured and paced appropriately. Trainee provides a clear summary of the session and agrees appropriate task-based practice that logically follows on from the session in a collaborative way. Checks the client/family understands the rationale for the task-based practice. Feedback is elicited using a measure, e.g. SRS, and discussed appropriately. | There is satisfactory structure to the session and pacing overall is adequate. Trainee provides a satisfactory summary of the session. Appropriate task-based practice is discussed. Feedback may be elicited using a measure, e.g. SRS, but is not explored further. | Trainee fails to meet the criteria above. Session is poorly structured; summary of the session is not provided or several important parts of the session are omitted from the summary; task-based practice is not agreed, is inappropriate, or is set with no attempts at collaboration (e.g. is prescribed by the trainee). Feedback is not sought by the trainee. |

| | | | |
|---|---|---|---|
| using a measure (e.g. SRS) and discussed in a highly appropriate manner. | | | |

| **7. Assessment of Risk (Not scored)** |
|---|
| AUTOFAIL: You must show that you have considered risk. It is not expected that a full risk assessment will be conducted in every treatment session unless indicated at assessment, however you must ask client/family whether there is any change to their risk /safety since last session. If you do not ask about risk, or if a full risk assessment is indicated (e.g. client/family expressed hopelessness, deterioration in mood) and not conducted, or is indicated but then conducted in an inappropriate manner (e.g. not in line with safeguarding processes and/or the thorough risk assessment teaching received at the University), the recording will be deemed an auto fail, even if all other assessment domains are of pass standard. NB: If the presence of risk is indicated (in relation to risk to/from themselves), this will require the trainee to go beyond solely covering the elements of the risk assessment list (risk to self, to others, from others, neglect). For example, as part of a risk management strategy, the trainee will need to ensure that the client/family is safe, to agree a plan with the client/family about whether any information needs sharing beyond this session (in particular gaining consent to share information with parents/carers if appropriate), create a safety plan if indicated and to give him/her clear instructions about how to make contact with the service (or other relevant services) in the event of a crisis situation |

## YIPP Case Study Assignment Guidance

### Assignment purpose

The purpose of this assignment is to write a case study to demonstrate your application of theory to clinical practice. This study will be of a young person / family from your current caseload either within your work in an inpatient unit, or from within the crisis team. You will demonstrate your overall understanding of basic psychological and therapeutic concepts and demonstrate use of evidenced based approaches to the young person's presenting mental health difficulties.

### Assignment description

You will write a 3000 case study of your work with a young person / their family from your caseload. You will need to include a detailed genogram of the family across three generations. Your formulation should be clearly documented, and should flow logically from your assessment of the young person's difficulties. This should feed into your goals for the therapeutic piece of work. The intervention should be clearly described, showing clear theory to practice links. You will need to evidence how you've monitored and evaluated the intervention being delivered (e.g. meaningful use of ROMs). This should be a real young person from your caseload, and therefore consent needs to be acquired, and confidentiality rules adhered to.

### Considerations when writing the case study:

The case study needs to show that you are working collaboratively. Developing a shared understanding of the presenting difficulty with young people and families is key to engagement and successful therapeutic outcome, so be thoughtful about how you achieve this.

The case study needs to demonstrate that you have a good working knowledge of common mental health difficulties in young people.

The case study needs to demonstrate that you are being guided by one of the formulation models you have been introduced to on the course. You will need to demonstrate that you are including wider contexts in the formulation such as developmental stage, family history, life events, diversity, culture power and oppression etc.

You should show your use of ROMs or structured assessment tools, and show how these have informed your approach.

You will need to demonstrate that you have considered risk.

You will need to demonstrate self-reflexivity throughout the case study.

**Marking guidelines for case study**

| **1. Clinical assessment skills 25%** | | | |
|---|---|---|---|
| Trainee demonstrates a robust assessment, including reason for referral, presenting problems, meaningful use of ROMs, goals for therapy, references relevant NICE guidelines. Trainee pays attention to issues relating to engagement and the therapeutic alliance. Your assessment will capture a detailed genogram across three generations, and outline a formulation model of the presenting difficulties. The formulation presents complex information effectively integrating contextual factors such as developmental stage, family context, life experiences, diversity, culture, power and oppression. Your assessment will include attention to clinical risk. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard.<br>Trainee demonstrates excellent formulation skills, integrating a wide range of contextual factors and clearly drawing from a formulation model. | Almost all of the criteria above are met to a good standard.<br>Trainee demonstrates good formulation skills, integrating a range of contextual factors and evidences drawing from a formulation model. | Most of the above criteria are met to a satisfactory degree.<br>Trainee demonstrates adequate formulation skills, integrating some contextual factors and shows some evidence of drawing from a formulation model. | Most of the above criteria are not fully met.<br>Little to no evidence of effective formulation skills.<br>Little evidence of the consideration of context, and little to no evidence of the use of a formulation model. |
| **2. Intervention & evaluation 25%** | | | |
| Trainee demonstrates a good working knowledge of common mental health presentations in young people. The intervention will be in line with evidence based practice/NICE guidelines, and will link back to the assessment and formulation. Rationale for the chosen intervention will be evident. Trainee will demonstrate the use of ROMs throughout the course of the intervention, and capture how these have informed their clinical approach. Enough detail should be given so that it is clear what intervention was delivered, but a session by session description is not required. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |

| **3, Links of theory to practice 20%** | | | |
|---|---|---|---|
| The trainee will demonstrate clear theory to practice links, using theory to guide assessment, formulation and intervention. You should refer to and make use of the relevant literature pertaining to this case, and include a critique of the theory informing your approach. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |

| **4. Reflective analysis / self reflexivity 20%** |
|---|
| The trainee should demonstrate a reflective approach to the work carried out and the use of methods / tools to aid this process. This should include rationales for the work carried out and demonstrate an awareness of professional issues, e.g. risk, ethical issues and power. Reflection may involve demonstrating an awareness of the way that your thoughts/assumptions/beliefs impact on the process and outcome |

| | | | |
|---|---|---|---|
| of the intervention with due consideration of how this may shape and develop your practice in the future. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |
| **5. Style and structure, including spelling, grammar and referencing 10%** | | | |
| The case study needs to have a clear structure and coherence to it. The trainee will demonstrate writing in a style that demonstrates an ability to make complex information accessible to the reader. This will include the appropriate use of language. Referencing is in line with APA guidelines. | | | |
| **70-100** | **60-69** | **50-59** | **Fail 0-49** |
| All the above criteria are met to a high standard. | Almost all of the criteria above are met to a good standard. | Most of the above criteria are met to a satisfactory degree. | Most of the above criteria are not fully met. |

## YIPP Case Study Feedback Sheet

Programme Member _____ Distinction •

Module PYCM Merit •

Pass •

Fail •

General Comments:

| | Fail (49% and below) | Pass (50-59%) Satisfactory | Merit (60-69%) Good | Distinction (70% and above) Very Good |
|---|---|---|---|---|
| Clinical Skills | • | • | • | • |
| Intervention & evaluation | • | • | • | • |
| Link of theory to practice | • | • | • | • |
| Reflective-analysis/ Self reflexivity | • | • | • | • |
| Style and structure, including spelling, grammar & referencing | • | • | • | • |
| Adheres to word count | | Yes / No | | |

| Clinical Assessment skills |
| --- |
| **General Comments:**<br><br>**To Improve Further:** |
| **Intervention & Evaluation** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Critical Evaluation/Outcome** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Links of theory to practice** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Reflective analysis/ self reflexivity** |
| **General Comments:**<br><br>**To Improve Further:** |
| **Structure & style, including spelling, grammar and referencing** |

**General Comments:**

**To Improve Further:**

If you are unclear on any feedback received, please do make an appointment to meet with your personal tutor to discuss this.

**YIPP 2023**

**Practice Outcomes Document – Please find the relevant templates on the YIPP ELE page, https://vle.exeter.ac.uk/mod/folder/view.php?id=2476778**

- **Formative POD A Template**
- **Summative POD B Template**
- **Summative POD C Template**

# YIPP Supervisor's Report

# Formative (end of Term 1)

Trainee Name:

Work base:

Name of workplace supervisor:

University Tutor:

Contact Details:

***Indicators outlined in blue/italics are to be used as a guide to help the supervisor reflect and comment on each aspect of supervision and should be deleted once the report has been completed.***

**Observed practice:** method/date

***Please outline the amount of supervision that has taken place and whether this has been face to face or remote***

**Ability to use supervision** **0 1 2 3 4 5 6**

Incompetent Expert

Please comment on the trainee's ability to use supervision and the supervisory relationship:

***Please consider the following in relation to the trainee's skills & attitudes in relation to supervision:***

- ***Attendance – regular/punctual?***
- ***Able to present material in an accessible way – to the supervisor & other supervisees***
- ***To give a clear presentation of the client, to enable the group to gain a clear understanding of the clients presenting difficulties***

- *Demonstrate preparation for supervision: selected appropriate supervision material*
- *Appropriate supervision question – reflecting relevant clinical issues & relevant to trainees learning*
- *Openness to feedback from the group and others*
- *Demonstrate ability to reflect on & learn from action points*
- *Ability to implement action points into clinical work & demonstrate this in the following supervision*
- *Ability to participate fully in the group supervision process and demonstrate professional practice within this setting – including: listening skills, respect of others in the group, showing empathy to others in the group & providing constructive criticism*
- *To demonstrate self-awareness: ability to recognise own thoughts, feelings, assumptions, beliefs and potential impact on the therapeutic an supervisory relationship*
- *Use of relevant paperwork prior to & during supervision*
- *Able to follow up on any homework tasks set from supervision e.g. reading up on a specific model*
- *Learning in supervision reflect trainees goals in their supervision contract*

**Areas of competency/strengths:**

Please rate and where relevant comment on the following areas:

Assessment and formulation 0 1 2 3 4 5 6

Incompetent Expert

Comments:

*Please comment on the trainee's ability to the below: If the trainee has not yet had the opportunity to demonstrate these areas, please just state this.*

- *Identify key areas for assessment in an inpatient, outreach or home treatment team context including the CYPs wider context*
- *Organise assessment detail according to diagnostic criteria*
- *Demonstrate an understanding of the relationship between assessment & formulation/hypotheses*
- *Ability to create a systemic alliance with family members*
- *Ability to complete a developmental/longitudinal formulation & access the relevant information from the client*
- *Conduct a thorough risk assessment – with appropriate follow up*
- *Demonstrate use of generic and problem-specific clinical measures*
- *Able to collaboratively agree SMART goals – reflected in the formulation*
- *Consider engagement issues and therapeutic alliance with whole family*
- *Awareness of any potential difficulties that may arise, e.g. literacy, communication difficulties, emotional literacy*
- *Have an understanding of the clients suitability for treatment within the service that they are able to offer*

Use of theory 0 1 2 3 4 5 6

Incompetent Expert

Comments:

*In order to help supervisors assess the ability of the trainee to appropriately apply theory to practice, whilst also appropriately deviating from protocol when necessary, it is suggested that the following questions could help structure the assessment of this:*

- *Which models/ideas have you used/is informing your practice?*
- *What is the rationale for your choice of model?*
- *How does your formulation relate to this model and your client's goals for treatment?*
- *What is your rationale for any interventions you have started to explore with the client/family?*

*It needs to be clear that trainees are applying their learning form the course direct into their clinical work and not 'relying on', or 'resorting to' using existing skills, or skills from another form of intervention.*

*Also, as appropriate, asking trainees to prepare the theory that they are using with their clients and bringing this to supervision to discuss in relation to their client and to share with peers.*

Techniques and skills 0 1 2 3 4 5 6

Incompetent Expert

Comments:

**Please comment on the following:**

- *The trainees ability to select and adapt appropriate skills that are relevant to the model and stage of therapy*
- *Demonstrate a creativity with the use of techniques*
- *Demonstrate appropriate developmental adaptations*
- *Implementation of techniques appropriate to the clients goals for therapy and abilities*
- *The trainee's ability to demonstrate a range of skills used/observed in the process of therapy, e.g. agenda setting, negotiating homework, and developing therapeutic alliance.*

**Areas to work on:**

Assessment and formulation:

Use of theory:

Techniques and skills:

Other:

**Action Plan/Future Goals:**

**Trainee's comments:**

Trainee rating of supervision: 0 1 2 3 4 5 6

Comments:

**Overall Evaluation of trainee:** Satisfactory/Unsatisfactory (please delete)

*For this stage in training.*

Signed (supervisor) ……

Signed (trainee) …….

Date ……...

# Submission methods

## Submitting through eBART

The link to submit assignments through eBART is on the Assessments tile on ELE. Click on the appropriate link to go to the Ebart submission page.

If trainees submit work and realise they have made a mistake, it is possible to correct it and re-upload another version unlimited times before the deadline.

Trainees should allow a good amount of time to upload work to Ebart prior to the deadline – IT Helpdesk suggest handing work in a minimum of three hours prior to deadlines so if something goes wrong there is time to speak to the IT helpdesk for assistance. **Computer failure/technical problems are not an acceptable reason for Mitigation.**

- Recording/Tape submissions and consent forms are currently submitted via MS Forms.
- Accompanying paperwork or written submissions must be submitted to eBART.
- Step-by-step instructions for uploading to eBART and MS Forms are available on ELE under the Submissions section.
- A copy of the MS Forms for your submissions is available on ELE under the Submissions section (it will appear one month before the submission deadline).
- A link to the relevant MS Form will be sent to you before your deadline via email as a reminder.
- Mitigated submissions should be submitted using the original MS Form link.
- For Resubmissions a separate MS Form link will be sent.
- There is a 1GB limit for Recording submissions so please check your file size before you submit. You can reduce file size when recording by setting a lower quality or resolution. Once recorded you can reduce file size through compression, by using software such as Handbrake.fr. Please liaise with your service IT team for guidance on what options are available to you

## Passing or failing assessments

For each assessment, two attempts are allowed.

### Passing an assessment and grade boundaries

**For all clinical practice assessments** an overall mark of at least 50% must be achieved and all compulsory sections must pass with at least 50%, including the risk assessment which is an auto-fail section. Marks below these levels will be deemed fails.

**For all academic assessments** trainees following the PGCert award must pass with a mark of at least 50%.Marks below these levels will be deemed fails.

**Pass marks are as follows:**

- **Clinical assessments**: 50% and above
- **Academic assessments (PGCert)**: 50% and above
- **Clinical Outcomes Documents**: Pass or Fail

## Failing an assessment

### *Failing a first attempt*

If a first attempt at an assessment fails the following applies:

- **Trainees can contact the teaching team for detailed feedba**ck (this is strongly advised).
- **A resubmission/resit date will be agreed** usually within 4 weeks of receiving notification of results
- **Marks will be capped** at a maximum 50% for second attempts .
- **In addition, marks for the whole module will be capped at the bare pass mark.**

### *Failing a second attempt*

If a second attempt fails the following applies:

- **For academic assessment fails, a PGCert (postgraduate route) trainee may be allowed to continue training by transferring to the GradCert (degree-level route)** where their attempt has received a mark of 40-49% (ie within GradCert pass boundaries).
- **In all other cases a second attempt fail constitutes a fail in the module and therefore overall fail of the programme.** Registration as a trainee of the University is terminated. Dependent on service policy, this may also mean termination of the trainee's employment.

# Late/non submissions

If trainees are experiencing difficulties in submitting assignments on time **they are strongly advised to speak to their personal tutor** who will be able to offer support and discuss ways forward.

**Penalties for late or non-submission without a valid mitigation are as follows**:

### *First submissions*

1. **Late submission within 24 hours.** If an assignment is submitted late but within an hour of the deadline 5% of the mark will be deducted. If an assignment is submitted up to 24 hours late without approved mitigation **marks will be capped for this assignment at the bare pass mark** (50%). Second attempts are still allowed if this attempt fails.
2. **Late submission beyond 24 hours.** Work submitted more than 24 hours beyond a submission date without approved mitigation will receive a mark of zero. Second attempts are still allowed. **Marks for the whole module are capped at the bare pass mark.**
3. **Non submissions.** These are marked at 0%. A second attempt is still allowed. **Marks for the whole module are capped at the bare pass mark.**

### *Second submissions*

1. **Late or non-submissions for second attempts without approved mitigation result in a mark of zero for the whole module and therefore a programme fail.** There is no 1 hour or 24 hour grace period. Training is terminated and the trainee's University registration is ended. The trainee's service employment may also end, but this is dependent on their employment contract conditions.

# Formatting work

All written assessments (case studies, reflective commentaries etc) should be word-processed with the following conventions:

- Use 1.5 line spacing on A4 paper.
- Use a font size of 12 pt.
- Use only Times New Roman, Arial or Calibri.
- Margins: 30mm on the left-hand side, 20mm on the right-hand side and 20mm for top/bottom margins.

- All pages (including appendices etc) should be numbered consecutively in one sequence starting with the title page as 1.
- Include the student number in the header but trainees should **NOT** include their name anywhere on the assignment, as this will prevent work being blind-marked.

## Word count guidance

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

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The following content is **not** included in a final word count:

- Title
- Reference list
- Appendices
- Words used in tables, graphs and other forms of data presentation (including titles of figures)

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)

## Citing and referencing

We require in text citations and a reference list (not a bibliography).

Psychology has adopted the American Psychological Association (APA) conventions as the standard for citations and references. References must therefore be completed using the precise details for APA style. We use the standard of 'a publishable article' and 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 trainees to consult these guidelines and copies are kept in the library or can be obtained online at www.apastyle.org and links to online training are on ELE. There are many web sites providing summaries of the APA Style Guide (a Google search will identify these).

The main conventions are as follows:

**Journal Articles**

A typical citation would be (Ablon & Jones, 1999) and the reference would appear as:

Ablon, J. S., & Jones, E. E. (1999). Psychotherapy process in the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, *67*, 6-7.

Another example would be:

Kasen, S., Cohen, P., Skodol, A. E., Johnson, J. G., Smailes, E., & Brook, J. S. (2001). Childhood depression and adult personality disorder - Alternative pathways of continuity. *Archives of General Psychiatry*, *58*, 231-236.

**Books**

A typical citation would be (Bateman, Brown, & Pedder, 2000) and the reference would appear as:

Bateman, A., Brown, D., & Pedder, J. (2000). *An introduction to psychotherapy* (3rd ed.). London: Routledge.

**Chapters in a Book**

If you have read a chapter in an edited book you would put the following citation in the text: (Aveline, 2006). In the reference section you would list it as:

Aveline, M., Strauss, B., & Stiles, W. B. (2005). Psychotherapy research. In G. Gabbard, J. S. Beck, & J. Holmes (Eds.), *Oxford textbook of psychotherapy* (pp. 449-462). Oxford: Oxford University Press.

**Citations in the Main Text**
Citing in text means referring to author(s) with the dates (e.g., Eells, 1997) so that the reader can then go to the References and find them in more detail.

Eells, T. D. (1997). *Handbook of psychotherapy case formulation*. New York: Guilford Press.

Reference citations for two or more works within the same parentheses. List two or more works by different authors who are cited within the same parentheses in alphabetical order by the first author's surname. Separate the citations with semicolons. For example: Several studies (Balda, 1980; Kamil, 1988; Pepperberg & Funk, 1990). Exception: You may separate a major citation from other citations within parentheses by inserting a phrase such as see also, before the first of the remaining citations, which should be in alphabetical order. For example: (Minor, 2001; see also Adams, 1999; Storandt, 1997).

There are many different instances of citing and referencing (eg internet resources, personal communication, conference papers, case examples, and you are advised to consult the Publication Manual for these.

## Plagiarism and academic misconduct

**Plagiarism and academic misconduct is a growing problem in all sectors of education,** and the number of reported cases in UK universities has risen dramatically in recent years.

**Plagiarism and academic or clinical misconduct are serious breaches of professional ethics.** Trainees can fail the programme, be expelled from University or even be prevented from pursuing a career as a YIPP.

Plagiarism and academic misconduct are defined as follows:

1. **Unauthorised collusion**, i.e. either aiding or obtaining aid from another candidate, or any other person, where such aid is not explicitly required and/or declared;
2. **Acting dishonestly in any way**, whether before, during or after an examination or other assessment so as to either obtain or offer to others an unfair advantage in that examination or assessment;
3. **Deliberate plagiarism** (see below for definition of plagiarism)
4. **Misrepresentation of clinical practice** (for example, in a case report or live patient recording)

### *Plagiarism*

The act of presenting someone else's words or ideas, whether published or not, without proper acknowledgement is called plagiarism. There are three main types of plagiarism, which could occur within all modules of assessment:

1. **Direct copying of text, or illustrations** from a book, article, fellow trainee's essay, handout, thesis, web page or other source without proper acknowledgement. *NB: this can occur unintentionally by failing to use quote marks accurately when quoting from a source.*
2. **Claiming individual ideas derived from a book, article etc as one's own**, and incorporating them into one's work without acknowledging the source of those ideas. This includes paraphrasing a source, or altering the material taken from the source so it appears to be one's own work.
3. **Overly depending on the work of one or more others without proper acknowledgement** of the source, by constructing an essay, project etc by extracting large sections of text from another source, and merely linking these together with a few of one's own sentences.

**Plagiarism and academic misconduct of any kind are highly serious, and there can be far reaching consequences.**

**In addition to ensuring you only ever submit your own work based on your own genuine clinical and theoretical practice we would strongly recommend you work through the online resource about Understanding Plagiarism on ELE to clarify the differences between academic honesty and plagiarism, and to identify ways in which you can directly or inadvertently plagiarise.**

**If you are in any doubt at all or are in anyway unsure how to submit work of clinical and academic honesty please contact your personal tutor.**

4. **The re-submission or re-use of the trainee's own work in another assignment** whether this was submitted at the University of Exeter or any other academic institution worldwide. (This is not intended to prevent a student from developing an academic idea over the period of a course, for example stating an argument in an essay for a particular module and then developing this argument in a dissertation, but to prevent the counting of credit twice for the same piece of work. However this operates at the discretion of the Panel considering the offence.)

# Appendix 5: Gaining patient consent and obtaining and recording live treatment recordings

## Gaining consent

For any live recordings consent must be gained from the patient. Consent forms detailing how to gain and record consent are on ELE. These differ whether gaining remotely, eg by telephone, or face to face in a clinic setting. Patients can consent for their sessions to be recorded or for their session information to be used for a clinical case presentation. Each requires a different form. For recordings, patients can consent for these to be used for assessment only or for assessment and teaching purposes.

## Guidance on recording live treatment recordings

For the competency skills assessment in Module 3 (PYCM119), trainees must submit a recording of a live treatment session with a client and or a client and family. All guidance for the assessments and recordings will be provided on ELE.

**Recordings must be clearly audible**

**Recorded patient sessions are highly confidential materials and as such should be treated with the highest standards of Information Governance.** Each workplace has its own policies and procedures for gaining consent, recording, storing and transporting recorded material. It is of paramount importance that trainees ensure they understand and adhere to these policies. If in any doubt trainees should consult their clinical supervisor/clinical lead/Information Governance Officer.

## Recording equipment and file formats

As part of the requirement to support trainees during training, employing services should provide trainees with the necessary equipment to record sessions in audio or video. Recording equipment should only be used that meets service Information Governance policy standards and **under no circumstances should trainees use personal devices to record patient sessions.** Please ensure that the recordings are saved as standard audio file types, eg .wav, .mp3 etc.

## Confidentiality

As far as possible trainees **should avoid identifying a patient by their full name or in any other way on the recording** (See Appendix 8). Consent forms, cover sheets and sound files must all be stored as separate files. Do not include the patient name or any patient identifiable information in any of the filenames.

## Obtaining and submitting consent for recording

**Prior to making any recordings for University assessment purposes, consent must be gained from the patient to record the session** for assessment and optionally teaching purposes. The University protocol for gaining and storing consent is as follows. **It is strongly recommended that trainees request consent for and record as many of their sessions as possible**. This gives the best options for selecting an appropriate recording for assessment, and additionally reflectively listening to sessions alone or with a supervisor is an excellent way of improving practice, and standard within psychological therapy practices.

### *Recording a face-to-face in-clinic session*

1. **Prior to the session, explain the request to record the session**, describing the key information included on the 'In-clinic Consent for Recording Sessions' form (see ELE). Patients can consent to their information being used for assessment only, or for assessment and teaching.
2. **If in agreement ask the patient to sign the relevant part(s) of the form**. This should be hand signed by the patient before the session is started.
3. **When you are ready to begin the session itself, start recording. Read out and ask your patient to confirm the Ongoing Statement of Consent.** If 'Yes', keep the recording running and continue with your session as usual. **It is vital that the verbal continuation consent given by the patient is clearly audible at the start of the recorded session.** Unless teaching staff hear this, they cannot mark the recording. If 'No', stop the recording.
4. **At the end of the session the trainee should fully complete all other form details** required.
5. **For subsequent sessions, repeat step 3 above.**
6. **Scan a copy of the completed form and submit alongside the recording and associated cover sheet**. It is good practice to offer a copy of the form to the patient and service policy may also require you to upload a copy to the patient's clinical notes.

### *Recording remote sessions*

1. **Prior to the first recorded session do not start recording but explain the request to record**, as detailed in the 'Remote Consent for Recording Sessions' form (see ELE). Patients can consent to their recordings being used for assessment only, or for assessment and teaching.
2. **If the patient is in agreement start recording. Read out and ask your patient to confirm whether they agree to the relevant parts of the Statement of Verbal Consent** on the form.
3. **Stop recording.** You have now created a short audio consent file.
4. **When you are ready to begin the session itself, start recording. Read out and ask your patient to confirm the Ongoing Statement of Consent.** If 'Yes', keep the recording running and continue with your session as usual. **It is vital that this ongoing statement of consent by the patient is clearly audible at the start of the recorded session.** Unless teaching staff hear this, they cannot mark the recording. If 'No', stop recording.
5. **For subsequent sessions, repeat step 4 above.**
6. **Complete, sign and scan the second page of the consent form.** Offer a copy to the patient and service policy may require that you also upload a copy to the patient's clinical notes.
7. **Submit the scanned document along with your recording, original audio consent file and associated cover sheet**.

## Failure to record consent

No session will begin to be marked until the appropriate fully completed consent is submitted and ongoing consent can clearly be heard on the recording. **Failure to obtain written or recorded**

**patient consent as indicated above will result in the recorded session not being marked, with a first attempt 'Fail' most likely being recorded**, and the service supervisor being advised.

## Storage and transportation of recordings

When transporting the recording and any associated cover sheets and consent forms, trainees must adhere to service policies. Recordings, cover sheets and consent forms must ONLY be stored and transported on secure, encrypted devices, in keeping with service policies.

## How recordings are stored after submission

**The programme timetable clearly identifies when and where recordings are submitted. Once accepted by programme staff, the following apply:**

1. On submission, files are stored with the trainee's name, date of submission and details of the assessment (e.g. PYCM119). There should be no other identifiable information.
2. Recordings are transferred to the University's secure SharePoint for YIPP by the Cedar PGT Administration team. Access is restricted to the Cedar PGT Administrators, Programme Lead, IT Lead and designated Markers only.
3. The markers consist of the YIPP teaching team and Programme Lead and for some submissions, the Programme Director and External Examiner. All staff are responsible for adhering to the Data Protection Act, Information Governance and University of Exeter policies and procedures.
4. Markers will access the recordings in a private and appropriate working space to maintain confidentiality.

All recordings are stored on the University's secure SharePoint as follows:

1. Recordings will be stored securely for up to 6 years from the date of submission, after which they will be securely destroyed.
2. Exceptions are where consent for use for training purposes has been given by the client and trainee has been given. Recordings are therefore kept on an ongoing basis for training purposes on University of Exeter YIPP course, and deleted once no longer required.
3. No identifiable client information is stored with the recordings.

Any failure in the process outlined above will be highlighted to the Programme Lead and the trainee in the first instance, followed by the trainee's manager. Where there is a continual failure to follow the agreed process, this will be escalated to the Caldicott Guardian or person responsible for Data Protection at each organisation so they may undertake a review.

# Appendix 6: Mitigation and Interruption

## Mitigation

If short term adverse circumstances in the workplace or in a trainee's personal life are impacting their ability to submit an assignment of appropriate quality on time, trainees may make a mitigation request for these circumstances to be taken into account and the type of consideration being requested, eg an extended deadline. Once the request is submitted, decisions are made by a Mitigation Committee which is separate from the teaching staff. Confidentiality rules apply, information will only be shared with the programme team if necessary and wherever possible this will be agreed with the trainee first.

### *Mitigation procedures*

Applications for mitigation will not always be accepted and **we would encourage trainees to speak to their tutor prior to submitting a request**. This page gives examples of acceptable reasons for mitigation: Annex F - Mitigation - Teaching Quality Assurance Manual - University of Exeter

The process for Mitigation is as follows:

1. **Speak to your tutor to discuss your concerns** (optional but encouraged)
2. Check on eBART whether your assessment has the option for a 72 hour, non-evidence based mitigation (only available with some assessments entirely submitted through eBART); otherwise you will need to apply for mitigation with evidence (process below).
3. **Download the Mitigation forms from ELE** and read the full mitigations guidance.
4. **Complete and sign the mitigation request form and ask your workplace supervisor to complete and sign the supplementary information form if mitigating on clinical (work related) grounds.** NB: if waiting for a workplace supervisor to sign the supplementary information form would cause a delay in submitting the form beyond the deadline outlined below, then trainees should submit the mitigation request form, and follow up as soon as possible with their workplace supervisor's form. Supervisors may 'sign' by typing their name however they must also then send a duplicate copy of the mitigation form to CEDAR-mitigations@exeter.ac.uk as verification.
5. **Submit your form any time before and no later than 24 hours after the submission deadline** of the assignment you wish to mitigate, by emailing CEDAR-mitigations@exeter.ac.uk (if supervisors are remote signing they must also email a copy of the completed form to this address). Requests submitted after this time will not be considered except in the most extreme of circumstances. You may optionally wish to submit work or attend an assessment as insurance in case your mitigation request is unsuccessful.
6. **You will need to include evidence for your mitigation request**, if you are unable to provide the evidence at the time of submitting your form, you have up to 10 working days after the assignment deadline to provide this.
7. **Your form and evidence will be reviewed by the Mitigation Committee** and their decision will be communicated via the Mitigations administrators
8. **If your mitigation request is accepted, a new submission deadline is agreed (or other consideration as indicated by the evidence**). Any work submitted that is no longer relevant will not be marked.

9. **If your mitigation request is late or rejected, any work you have submitted will be marked as usual**. If you have not submitted work, late and non-submission rules apply (see Appendix 4).

## Interruption

Whilst Mitigation is for short-term adverse circumstances, if a trainee is experiencing longer term (6-8 weeks or more) circumstances that make continuing with the course or submitting assessments of an appropriate quality difficult they may be able to Interrupt, i.e. pause their studies and resume again at a later date. Interruption is a more flexible process for longer term, ongoing difficult circumstances as trainees may request Interruption without knowing a specific date of their return. Interruption is generally for periods of between 2 months and 1 year, although in exceptional circumstances a second year may be agreed.

**The process for Interruption is as follows:**

1. **Trainees should have an initial conversation with their personal tutor to see if Interruption is a practical option**, and similarly with their service. Service protocols may differ from University procedures, so trainees sure ensure this is a viable option with their service.
2. **If Interruption is indicated, trainees should send an email to YIPP@exeter.ac.uk** requesting Interruption. They will be contacted by the mitigation admin team and supported to fill out a brief form outlining reasons for the request. NB trainees do not have to disclose extensive details of their adverse circumstances, but enough information that those reviewing the request can make an appropriate decision. For example, if a trainee has been signed off sick by their doctor, they can state this but are not obliged to detail the nature of the illness. Trainees will be asked for a date they expect to return to work, however this date can be changed at any time as new information arises or circumstances change.
3. **The request is forwarded to the Programme Lead and a member of the senior programme staff, who make a joint decision** as to whether to agree Interruption.
4. **If Interruption is agreed, training is suspended**.
5. **Nothing further occurs until the trainee is able to return to work. The preliminary date for return can be changed as circumstances resolve or continue.** When the trainee is ready to return, the trainee's academic tutor and workplace supervisor liaise together with the trainee to agree a return schedule. If the trainee had not completed all taught days by the time of Interruption, they will be able to join a future cohort at the same point in the timetable at which they Interrupted (or earlier by agreement). New deadlines for assignment submissions are agreed that take into account the time needed for the trainee to rebuild an appropriate caseload etc.

**If any trainee is experiencing ongoing adverse circumstances that affect their ability to engage with the course and produce work of an appropriate quality, we would strongly advise a discussion with their academic tutor to find a supportive way forward.**

# Appendix 7: Further educational and emotional support

## Emotional and wellbeing support

Any form of professional training is potentially stressful. We recognise that the three components of the course: University attendance, clinical practice and independent study may be difficult to balance, and the nature of the work itself can be very demanding.

Within the programme we hope to promote a mutually supportive atmosphere in which trainees feel able to share concerns and issues with one another, with the programme team and with clinical supervisors. However, we recognise that the programme team and supervisors cannot necessarily provide all the support that may be required.

**Other sources of support:**

- **Academic Personal Tutor:**
  The academic personal tutor is there to support trainees if they begin to experience difficulties of any kind: personal, academic or otherwise that impact on their training. In the event of significant difficulties that may impede a trainee's ability to study, the personal academic tutor can liaise with the practice based clinical supervisor to discuss a supportive way forward. This can be far better than a trainee trying to 'keep going' when they are unable to produce work of an appropriate quality that may then result in an assignment or even programme fail.

- **Wellbeing Services**
  The University Wellbeing Services offer free and confidential support for personal problems, emotional difficulties and difficulties with mental health, including 1-1 CBT and counselling as well as more general support, advice and signposting. It is available to all students of Exeter University including trainees. An initial telephone appointment is offered and from there an advisor will help work out the best route of support. Appointments are available by telephoning **01392 724381** or email wellbeing@exeter.ac.uk.

  You can read more or book an appointment online here: https://www.exeter.ac.uk/wellbeing/

## Support with additional learning needs, disabilities and health conditions

The University AccessAbility team offers support to students with disabilities, physical or mental health conditions and learning or literacy difficulties – or any circumstance that may impact negatively on a trainee's ability to engage with study and meet assessment requirements. The service endeavours to provide facilities and equipment suited to people's individual needs www.exeter.ac.uk/accessability.

Following an assessment with the AccessAbility team, if recommendations are made to support the trainee with their learning these will be documented in an Individual Learning Plan (ILP) which programme staff can then use to make reasonable adjustments to the course or assessments. These could include a range of adjustments such as extra time in exams or separate rooms, course materials and lecture slides given out early or on coloured paper, additional time for academic assignments or anything else the team assess as appropriate. Without a documented ILP, the teaching team are unable to make any changes.

**Any trainee who could benefit from an ILP is advised to contact the AccessAbility team as soon as possible – even before the course starts if adaptations could be helpful.**

## Library facilities and services

The main library facilities are at the University of Exeter Streatham Campus. The library catalogue, including access to electronic journals, and facilities for reserving and renewing books also available online www.exeter.ac.uk/library.

Library support is organised by subject, and this is the specific page for Psychology students: https://libguides.exeter.ac.uk/psychology . As well as access to all the Psychology texts, databases and resources the Library offers are highly helpful online tutorials, links and information, plus 1-1 support if needed around about the following:

- how (and where) to effectively search for articles, research, books and papers
- how to evaluate source materials and how to reference them
- how to understand different academic materials, eg statistics, reports, systematic reviews, policies, guidelines etc
- where to find statistics

## Access to external libraries and inter-library loans

Trainees can also access other higher education libraries via SCONUL (an arrangement between many higher education institutions) and are entitled to Inter-Library Loans.

More information can be found on the University Library website at www.exeter.ac.uk/library, or direct from SCONUL- www.sconul.ac.uk/sconul-access .

## 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 all students of the University including trainees, 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.

This support can be highly beneficial for anyone, especially if a trainee has not worked at post-graduate level before.

# Appendix 8: Confidentiality

Working as a YIPP necessarily involves working with patients around distressing, sensitive and difficult issues. As practitioners we are given the power to influence the lives of patients who may be very vulnerable and this requires a high degree of responsibility in respecting confidentiality and being fully aware of information governance. It is also a job that requires emotional resilience, self-awareness and self-care.

## Patient confidentiality

The teaching team aim to facilitate an open learning environment in which information is shared appropriately and respectfully between staff, trainees and relevant others to enable trainees to develop and to ensure appropriate patient care.

**When sharing information about patients or cases trainees and staff alike must do so:**

i. **in a manner most likely to protect the identity of the patients, both directly and indirectly.** This means not disclosing any directly identifying information, such as names, identifying details of their contact with the service eg dates/times, the name of the service, clinic or location they attended etc, In addition no details should be disclosed that are so specific about the patient or their family that they could pinpoint who the patient is. Examples are: names of family members; GP; home, school or workplace locations; specific job; unusual health conditions; unusual hobbies or interests etc.

ii. **in a manner and setting which is respectful,** for example not using inappropriate or caricaturising illustrations, captions or representations etc.

iii. **in a manner which honours the limits of confidentiality,** explained previously to a patient.

iv. **with an understanding that no member of the group will disclose any information** about such patients outside the sessions.

## Trainee confidentiality

It is recognised that we all have life experiences and relationships that have shaped who we are and that we can all be emotionally affected by the work we do. It is for this reason that the programme promotes reflective practice, to ensure that we are mindful of the way our own experiences and assumptions about the world, people and relationships may influence our therapeutic practice.

We would like to promote an ethos which allows trainees the opportunity to reflect openly and honestly on the challenges of their role. This means that trainees may sometimes share personal information about themselves with staff and each other. Trainees can expect that colleagues and staff members will be thoughtful and sensitive about their right to confidentiality. As a staff team we also have to balance this with the need to ensure that we are protecting the interests of potential patients; and to ensure that trainees are able to provide appropriate clinical interventions. For this reason, we provide the following information about confidentiality of trainees:

i. **The details of any personal material remains confidential within the context in which it is shared.** It is not fitting for any trainee to disclose information about another, in their absence or presence, within the course or in conversation outside of sessions, without agreed permission.

ii. **The only exception is if there are concerns about an individual's safety** (child or adult). In such cases trainees should consult a member of the programme team, and when possible, inform the person concerned that they are doing this and explain why.

iii. **Trainees should expect that information about day-to-day aspects of training will be shared with relevant individuals** (e.g. the trainees' lead/service manager/supervisor as identified). This will routinely include sharing trainees' marks for the assessments within the programme and sharing an overview of the trainees' progress. Trainees will have consented to having this information shared as part of the application form.

iv. **Personal matters affecting training can be kept confidential within or from the programme team**. Where a trainee shares personal details regarding circumstances affecting their training or ability to provide appropriate patient care, there should be a discussion about how best and with whom to share concerns. Although trainees should expect that the teaching team will need to discuss with one another how best to handle any issues, as far as possible this will be done in a way which keeps the specific details of trainee's circumstances confidential, even between members of the teaching team if the trainee desires. If necessary a confidentiality agreement can be drawn up between the trainee and appropriate staff/supervisors.

v. **If a trainee discloses information indicating personal risk of harm to self or others**, **it is necessary to inform the trainee's service and/or their GP**,in accordance with standard mental health practice. Trainees will have consented to this as part of the application form. Where risk is a concern the teaching team will always, where possible, seek to inform others with the trainee's full knowledge.

## Ground rules for groups, tutorials and supervision

- **Work with respect for each other**, even if you disagree.
- **Accept individual responsibility** for individual behaviour.
- **Pay attention to issues of difference** such as gender, gender reassignment, age, race and ethnicity, disability, marriage and civil partnership, pregnancy and maternity, religion and belief, sexual orientation, remembering that each person's experience is true for them and valid.
- **Clarify limits of confidentiality** and adhere to these.
- **Make your own decisions about how much information you wish to share** about personal or occupational matters.
- **Remember you are the "expert" about your own life** – any questions or suggestions from others may be rejected as inappropriate.

## Supplementary guidance on the use of Social Media

**All of the above applies as much to social media as to any other mode of communication**. The British Psychological Society (BPS) Ethics Committee acknowledges that members are using social networking sites to communicate with friends, family, professionals and clients. The Ethics Committee has created a supplementary guidance document in line with the Society's Code of Ethics and Conduct that provides practical advice for using social networking sites responsibly.

# Appendix 9: Online Learning

All YIP teaching with the university will be delivered online using Zoom

Zoom links for teaching sessions are found in the timetable. ELE should be checked regularly for the latest version of the timetable.

Once registered /enrolled with the university, all trainees will have their own university Zoom account. Guidance on how to login to this account can be found here, How to download and login to Zoom (sharepoint.com),

Further guidance about how to get the most out of Zoom can be found here, Guides to using Zoom (sharepoint.com)

Any problems accessing the training should be reported to the Programme Administrator, YIPP@exeter.ac.uk.

IT support can also be reached via SID | SID | University of Exeter

# Appendix 10: Attendance – missed session plan

## PGCert Youth Intensive Psychological Practitioner (YIPP)

## Missed Session Learning Activity: Guidance for Students

The PGCert YIPP programme requires a high level of attendance. However, we appreciate that unforeseen circumstances do arise that make it difficult to attend occasional sessions. We therefore have provision to complete missed session learning activities. *This does not apply to missed University supervision sessions.*

**The decision as to whether a Missed Session Learning Activity plan requires completion for any given absence will be made by the academic team in consultation with individual trainees.**

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 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 – discussion, role play or similar – with your peers or your clinical supervisor.**

The missed session learning activity *must be agreed with your Academic Tutor 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.

# Missed Session Learning Activity Record

**Student name:** **PYCM number of module:**

**Date and title of session missed:** Lecturer:

| **Learning outcomes from the missed session**<br>Obtainable from ELE or from the lecturer |
|---|
| |

| **Proposed plan to meet learning outcomes**<br>To be agreed by your Academic Tutor prior to completion |
|---|
| |

**Critical reflection on your learning**
Write a reflective piece of up to 500 words focussing on your theoretical and clinical learning

**Summary of learning:**

Evidence how you have met the learning outcomes for the session

Name of Academic Tutor: _____

Signature of Academic Tutor (in agreement of plan): _____ Date: _____

Signature of Academic Tutor (plan carried out): _____ Date: _____

*NB. Completed and Signed Missed Learning Activity Plans must be presented in your portfolio for submission at the end of your course.*

# Appendix 11: Risk Assessment

## Risk Assessment - Assessment

- All introductions and questions should be stated clearly and without euphemisms or apologies.
- There must be no leading or assumptions, and no double questions.
- Any positive, vague or ambiguous answers must be funnelled to gain clear, accurate details.
- The following must be asked as a minimum, service policy may dictate additional details should be asked or given.

| | |
|---|---|
| **Current Suicide** | **Separately** ask about:<br>• Thoughts<br>• Plans<br>• Actions<br>*NB if asking about 'intent' also ask about Thoughts, Plans and Actions* |
| **Past Suicide** | **Separately** ask about:<br>• Thoughts<br>• Actions |
| **Protective factors** | Ask clearly about protective factors, explaining what protective factors are as needed. Funnel to gain any details if needed. |
| **Current Self-Harm** | **Separately** ask about:<br>• Thoughts<br>• Actions<br>*NB if asking about 'intent' also ask about Thoughts and Actions*<br>*If needed, explain questions are about harming oneself in <u>any</u> way, to distinguish from suicide attempts or only overt means such as cutting, burning etc* |
| **Past Self-Harm** | Ask about:<br>• Actions |
| **Risk to Others** | Clearly ask if the patient feels they may pose a risk of harm in **<u>any</u>** way to **<u>anyone</u>** else.<br>*NB harm can take many forms: physical, verbal, emotional, psychological, financial etc* |
| **Risk from Others** | Clearly ask if the patient feels they may be at risk of harm in **<u>any</u>** way from **<u>anyone</u>** else.<br>*NB harm can take many forms: physical, verbal, emotional, psychological, financial etc* |
| **Self-neglect** | Clearly ask if the patient is not looking after themselves in any way which may be harmful eg (but not limited to) not washing themselves or their clothes/bedclothes, not eating or drinking well enough, using harmful substances, not taking medication or getting medical help etc |
| **Dependents** | Clearly ask if there is anyone who depends on the patient for their care in any way, adult or child, directly or indirectly |
| **Neglect of Others** | Clearly and separately ask about:<br>• Neglect of any identified dependents (adults or children)<br>• Anyone else the patient may feel they are neglecting |

**IN ALL CASES, IF RISK IS IDENTIFIED YIPPS <u>MUST PRIORITISE</u> FOLLOWING SERVICE PROCEDURES TO ENSURE PATIENT AND/OR OTHERS ARE SAFEGUARDED.**

## Risk Assessment - Treatment

- For each item, previously understood information should be reflected back and then the patient asked if there are any changes
- There must be no leading or assumptions, and no double questions.
- Any changes or any vague or ambiguous answers must be funnelled to gain clear, accurate details.
- The following must be asked as a minimum, service policy may dictate additional details should be asked or given. Trainees will not be marked down for this, but it is not required.

<table>
<tr><td>Current Suicide</td><td colspan="2">If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:<ul><li>Thoughts</li><li>Plans</li><li>Actions</li></ul>If no risk was previously identified Thoughts, Plans and Actions can be reflected back together eg, “With regards to suicide, last time we met you told me you weren’t experiencing any thoughts of wanting to end your life, hadn’t made any plans and hadn’t taken any actions towards ending your life – has anything changed?”</td></tr>
<tr><td>Protective factors</td><td colspan="2">Reflect back previously understood protective factors and ask if there have been any changes.</td></tr>
<tr><td>Current Self-Harm</td><td colspan="2">If any risk has been previously identified, <u>separately</u> reflect back and ask for changes:<ul><li>Thoughts</li><li>Actions</li></ul>If no risk was previously identified Thoughts and Actions can be reflected back together eg, “With regards to any kind of self-harm, last time we met you told me you weren’t experiencing any thoughts of hurting yourself and hadn’t taken any actions towards self-harm in any way – has anything changed?”</td></tr>
<tr><td>Risk to Others</td><td>Reflect back previously understood risk status and ask if there have been any changes.<br>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</td><td rowspan="2">If no risk was previously indicated Harm to and From Others can be reflected back together, e.g. “Last time you told me you didn’t feel you posed a risk of harm to anyone, and that no one was posing any risk of any kind to you – has anything changed?</td></tr>
<tr><td>Risk from Others</td><td>Reflect back previously understood risk status and ask if there have been any changes.<br>NB harm can take many forms: physical, verbal, emotional, psychological, financial etc</td></tr>
<tr><td>Self-neglect</td><td>Reflect back previously understood risk status and ask if there have been any changes.</td><td rowspan="2">If no risk to self or others was previously indicated Self-neglect and Neglect of Others can be reflected back together, e.g. “Last time you told me you didn’t feel you were neglecting yourself, your dependents [insert dependents’ names], or anyone else who may depend on you in any way – has anything changed?</td></tr>
<tr><td>Neglect of Others</td><td>Reflect back previously understood neglect/lack of neglect and ask if there have been any changes for:<ul><li>Identified dependents</li><li>Anyone else</li></ul></td></tr>
<tr><td>Dependents</td><td colspan="2">Reflect back previously understood dependents/lack of dependents and ask if there have been any changes.</td></tr>
</table>

**IN ALL CASES, IF RISK IS IDENTIFIED YIPPS <u>MUST PRIORITISE</u> FOLLOWING SERVICE PROCEDURES TO ENSURE PATIENT AND/OR OTHERS ARE SAFEGUARDED**