SECTION 21: CLINICAL REPORT GUIDELINES

PART 1: GENERAL INFORMATION ABOUT CLINICAL REPORTS

AIMS, FORMATS AND BREADTH OF CONTENT

Aims

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

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

Formats

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

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

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

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

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

SCHEDULE OF SUBMISSION

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

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

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

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

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

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

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

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

This is defined as at least:
- one piece of clinical work with a child or young person (under 18)
- one piece of clinical work with an adult of working age or person in later adulthood (aged 65+)

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

b) A range of severity and chronicity of presentation:

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

c) A range of psychological approaches:

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

d) A range of settings:

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

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

In summary, the "portfolio" of reports should ideally include:

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

PRESENTATION OF REPORTS

Basic formatting
Reports should be:

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

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

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

All citations and references should be in APA format.

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

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

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

- The front (cover) page
- References
- Appendices

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

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

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

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

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

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

CHOOSING A PIECE OF CLINICAL WORK

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

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

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

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

SUPPORT FOR WRITING THE REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

GAINING INFORMED CONSENT FROM CLIENTS FOR CLINICAL REPORTS AND FOR RECORDINGS

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

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

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

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

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

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

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

Gaining consent from families or groups

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

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

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

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

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

Submitting reports when client consent is not obtained
The purpose of writing a clinical report is educational, and it differs from a clinical record in many respects – for example, it is anonymised, and some clinical details maybe withheld in order to preserve confidentiality. Its focus is often on the rationale for intervening as much as it is on the intervention itself, and it contains reflections on the clinical work that include the trainee's personal reactions to the client. This educational purpose means that there may be some types of clinical work that it would be appropriate to submit even where client consent is difficult to obtain – for example, with clients who have been very hard to engage (perhaps because they have paranoid thoughts, or the intervention is characterised by marked interpersonal strains). As such there may be occasions where the educational purpose of a clinical report justifies its preparation in the absence of client consent. Because this is an exception to the usual requirement the following governance procedure needs to be followed.

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

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

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

GAINING CONSENT FOR RECORDING SESSIONS

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

Ensuring the security of session recordings using encryption

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

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

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

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

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

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

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

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

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

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

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

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

Requesting an extension
see Section 25 of the Training Handbook.

Procedure for submitting reports

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

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

The Clinical Report should include a front sheet, stating:

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

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

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

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

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

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

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

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

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

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

PART 2: GUIDELINES FOR THE FORMAT OF REPORTS

General comments about the structure and content of reports

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

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

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

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

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

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

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

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

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

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

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

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

CONSIDERATION OF THE CONTEXT

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

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

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

If you do use a diagram it should be labelled as a figure, and referred to as such in the text.

Measures
You should include any methods you used to evaluate your work, and any numerical data you collected (raw data is usually included in an appendix).

It is good practice to report scores with confidence intervals (where these are available), as well as standard scores/ percentiles/ descriptors.

Wherever such data is available, there should be an indication of the clinical implications of any test results. For example, stating that a client has a BDI of 32 does not convey very much. Reference to normative data will tell you that this indicates a fairly high level of depressive symptoms. On this basis the score would be reported as:

"The client scored 32 on the BDI, which would indicate a high level of depressive symptomatology".

Another example might be:

"The client's score of 23 on the Recognition Memory Test places them at the 10th percentile".

If you have test results from previous recorded assessments, it will be helpful to contrast these with your results, and indicate the implications both of stability and of change.

References

Where relevant, you should cite pertinent literature. Bear in mind that the purpose of references is to give academic authority to your assertions, and to guide the reader to the source of major ideas that you are discussing. This should be done judiciously. We are not expecting a long reference list, and more references do not necessarily make a report more authoritative – their relevance to your discussion should be the basis for their inclusion. All in-text citations and the reference list must be presented in line with APA guidelines.

COMPULSORY REPORT (CLINICAL REPORT 1): ASSESSMENT REPORT

Aim
The aim of this report is to describe the assessment of a psychological problem, and the results of that assessment.

Competencies to be demonstrated
The report is intended to allow you to show that you have been able to plan and carry out an assessment that addresses the question(s) presented in a referral.

What the markers are looking for
The markers will be looking for evidence that you have identified the appropriate questions that need to be addressed, and used your theoretical and practical knowledge to plan a suitable approach to attempting to answer them. (In this context the use of theory is quite specific – this is described below in the paragraph on content.)

They will want to see how you engaged the client in the assessment process, a clear rationale for the range of information gathered, and that this information is interpreted sensibly.

Examiners will expect hypotheses about the presenting issue/s, but won't expect a full formulation, especially if (as is likely) the assessment is only partly complete or the clinical work is at a very early stage. Distinguishing between a set of "hypotheses" and a "formulation" isn't easy – formulations are, after all, made up of hypotheses. In the context of the marking criteria, the distinction is made because:
a) in the assessment phase any ideas you have about the client are probably tentative (you may well be missing some important information). This means that you are more likely to hypothesise, rather than to derive a fully-formed formulation (which may well be premature).
b) formulations are internally coherent. In contrast, when attempting to make sense of ambiguous information, you may come up with a number of alternative hypotheses, some of which may even be contradictory.

If you are presenting a set of hypotheses, it is a good idea to indicate what additional information would be useful in order to clarify any areas of uncertainty, or decide between competing hypotheses.

Where you have used standardised measures, the markers will want to see that you have understood the properties of the measures and are aware of their strengths and limitations.

They will also want to see that you can reflect on and be appropriately critical of the assessment.

Type of material
Any type of clinical work would be suitable. For example,
- an assessment for a direct or an indirect psychological intervention
- an assessment aimed at clarifying the nature of a presenting difficulty
- an assessment aimed at determining whether a problem is related to psychological or neurological factors

Assessments could be based largely on an interview format, could use formal procedures, or employ a mix of the two. The format will usually depend on the nature of the referral.

You can report on joint work, but if this is the case you should have been responsible for most of the work reported. You cannot report on work you have observed.

Content
Bearing in mind the general comments above, reports will usually include consideration of the following:

- The service context in which the referral took place, and the way in which this influences and shapes decisions about the scope of the assessment and the assessment procedures.
- How the assessment procedures used can answer the questions posed by the referral. For example, if psychometric assessments were used, what were the reasons for choosing the specific assessment? If the assessment was for psychological therapy, how and why was the interview conducted as it was? If a client was assessed on a ward, and information gathered from specific members of the ward team, what was the rationale for choosing who to talk to?
- What cultural and contextual factors were identified, how did these influence the assessment, and how did you take account of these in your understanding and approach to the work?
- What models were drawn on in conducting the assessment. Markers will be aware that in some settings a clear model is used from the outset, while in others a more pantheoretical approach is adopted. Whatever the starting point, as clinical facts emerge, theories and models will make certain lines of questioning more or less pertinent, and this sort of structuring is worth making explicit in your report. For example, if it became clear that the major problem was one of panic, a CBT model of panic disorder would lead you to ask certain sorts of questions, and you should (broadly) indicate how the model led you to these lines of inquiry.
- What information was gathered. This will need to be structured so as to present a coherent account of the information gathered. A common challenge will be to decide which material is relevant, and which peripheral.
- Brief considerations about the presence of risk (e.g. to self, to/from others, substance misuse, etc.) and, if present, details about how risk was assessed, monitored, and/or managed.
- A written formulation, linking the presenting material with relevant psychological evidence and theory.
- Any 'process' issues which were pertinent – for example, difficulties in engagement, or ways in which a standard assessment procedure needed to be adapted to meet the needs of the client.
- How the information gathered clarifies the referral problem. How do you now understand the clinical problem, following the assessment and in the light of the information you collected?
- What clinical recommendations can be made on the basis of the assessment? How does your assessment help you to define what should be done next? What areas do you need to know more about?

In concluding the report it will be essential to reflect on the assessment as a whole. This includes appraising what was good about your work, as well as being appropriately critical. However, there is no obligation to find fault – being 'critical' simply means being 'thoughtful'. This includes showing awareness of your own limitations at this stage of training, as well as any limitations which reflect the context within which you work. For example, while in an ideal world you might have talked to all members of a family, practical problems, or issue of confidentiality, might preclude this. A thoughtful discussion recognises these issues as realistic constraints. Setting unrealistically high standards for yourself or others would not be a good example of reflection.

Additional material which may be required
The results of standardised tests should be included in full in an appendix.

COMPULSORY REPORT: TRANSCRIPT-BASED THERAPY PROCESS REPORT

Aim
The aim is to show how you link the model of therapy you are applying to the process of the therapy you carried out. The core of the report is a reflective commentary, based on a transcript of your work.

Competencies to be demonstrated
The report allows you to demonstrate the ability to use clinical skills within a chosen and specified theoretical framework and provides evidence of your capacity to critically reflect on your own work as a clinical psychologist.

What the markers will be looking for
Although markers will be expecting the clinical material to demonstrate *basic* overall competence, this is not the main point of the report. The major focus lies with the commentary you offer, which will reflect on:

- what you were attempting to do
- how you did it
- any difficulties or issues which arose and
- the impact of the intervention both on you and on the client

Markers will pay particular attention to your ability to demonstrate links between the model you are using and the techniques you employ. As above, this does not mean that they expect you to apply them perfectly – only that you show an understanding of why you were doing what you did.

Content and suggested structure
a) Choosing appropriate material
Selecting appropriate clinical material is the critical initial step. You should be clear about the clinical themes and interventions you want to demonstrate, and be certain that the material will illustrate these.

It is best if material chosen for this report comes from a therapy which you are recording routinely. It is not helpful to record a sessions on a 'one-off' basis just to meet requirements for this report – both you and the client will probably be over-conscious of the recording process.

b) Choosing extracts from the recording
Usually the report will be based on a recording of a single clinical session. Given the word limit you cannot include all the material, so you will have to think carefully about what to include. The usual strategies are to:
a) identify extracts from across the session which exemplify the themes which you wish to draw attention to, *or*
b) select a continuous extract, again because it illustrates some relevant themes.

Alternatively you might want to focus on the way an important clinical issue or theme evolved over a number of sessions. On this basis, you could present short extracts from a series of sessions, rather than a single session. However, the extracts should be carefully chosen to illustrate both the clinical focus and its evolution.

Choosing appropriate extracts is important – they should be selected to illustrate the points you wish to make.

c) Overall structure of the report

i) Introduction

Start by outlining where the focus of the report will lie (and hence the reasons for choosing the extract(s)). For example:

This report will focus on a rupture in the therapeutic alliance, and the way in which this rupture helped to cast light on some important dynamics in the therapeutic relationship.

This report will focus on the use of guided discovery in the assessment of a client, and its value in helping to establish a more precise understanding of the client's problems.

After this you should outline the presenting problem (including a diagnosis where this is relevant), any other relevant issues relating to the client's background and the clinical context, and the assessment, formulation and intervention plan. You should identify the theoretical approach you are employing, and briefly review why you adopted this approach . You should also indicate the session number from which the extract is drawn (e.g. "this was the third session in a 15-session therapy"). In some instances it may be relevant to indicate the immediate treatment history that preceded the fragment you are presenting.

This outline should not be too long – the idea is to set the scene, and give enough information to orient the reader to the focus client/s and to the clinical material.

ii) Extracts and commentary

Extracts should be transcribed, and speaker turns numbered to facilitate cross-referencing.

In most (but not all) instances it will be best to integrate the commentary with the transcript. If you do this, it is important to make it easy to distinguish the transcript from the commentary by using a different font or italics (and see comment below regarding the word count and transcripts).

You should then comment on the transcript, describing the therapeutic process as you understand it. For example:

- What I was intending to do was to assess the meaning of X to the client, though this seems to have been heard in a very different way by the client, who…
- I was trying to maintain a collaborative framework for implementing guided discovery, but the client seemed to react angrily to what I had thought were gentle probes…
- The client's specific reference to X suggested that this would be a good point at which to make an interpretation that attempted to draw their attention to the relationship themes which were central in the formulation
- At this point the client seemed to withdraw into herself, and after what seemed a long silence I began to wonder if…

This commentary should track the transcript, trying to integrate:

- your sense of the therapy process and the skills you were employing
- your moment-to-moment intentions, e.g. "what I was hoping to do here was to shift the focus from X to Y"
- because I thought this might raise the client's anxiety if broached too directly, I thought I'd start by raising issue A rather than issue B
- the way in which your subsequent actions are adapted to the client's reactions.

It is very important that the commentary should indicate how your interventions relate to the model you are applying. For example, you may refer to the model to help explain why you did something, or how you understand the client's reactions to your interventions. Bear in mind that your sense of being informed by your model would also be illustrated by noting where (and why) you went "off model". You are not expected to adhere perfectly to a model all the time; models are intended to inform, not to be followed blindly.

The commentary should also be appropriately reflective: as well as noting what went well you should also identify what did not go as well as intended, and try to account for these more problematic moments. Bear in mind that a reflective commentary is not a matter of simple self-criticism; it is more a matter of conveying your understanding of the ways in which the intervention might have worked better – for example, suggesting a rephrasing that might have been clearer to the client, or identifying possible reasons why the client might not have picked up on your intervention in the manner which you expected.

You do not need to comment on *every* exchange between yourself and the client unless there is a good reason for focusing at this level of detail.

iii) Reflections
The final section of the report will be a reflection on the material as a whole. This should include points of future learning. It may also include reflections on, for example:

- the relationship between your intentions and the actual impact of your interventions
- your experience of trying to apply the specific theoretical framework
- any specific difficulties or dilemmas you experienced during the session
- how supervision informed the piece of work or decisions taken

Word count and transcripts
The word limit ***excluding*** the transcribed extracts is 3000 words. The transcript itself should be a minimum of 400 words and a maximum of 1000 words

Guidelines on the recording
Although you do not need to submit the recording with the report, the examiners can ask for a copy, and you should ensure that this is available should they request it. It should be of good quality and the dialogue should be clear and audible.

Gaining consent for recording
Recording a clinical session requires the informed consent of the client. They must be made aware that the recording and commentary will be listened to by supervisors and could be listened to by third parties at the University, and that this may include an external examiner.

Consent forms for recording and for the use of clinical material in a clincial report can be found on the course website.

The consent forms should be filed in the client's clinical notes. It should not be submitted with the report, as this would breach confidentiality by revealing the name of the client.

Safeguarding recordings - encryption: It is essential that steps are taken to safeguard the security and confidentiality of recordings by encrypting recordings. Because this cannot be done directly from the hard disc within the recorder you will need to transfer and encrypt the recording to a USB stick at the earliest opportunity, and delete the file on the recorder. Section 8, Appendix 5 identifies how this can be done.

Most Trusts insist on the use of encryption to assure client confidentiality – trainees should make sure that they follow local policy guidance.

Retaining the recording
Recordings should only be retained for as long as they are required. In the case of the recording on which the transcript report is based this means retaining it until it is clear that that an external examiner will not request it as part of an assessment for educational purposes – in practice at the end of the course.

OPTIONAL REPORT 1: SINGLE CASE STUDY

Aim
The report is intended to give trainees the experience of conducting and writing up a piece of clinical work using standard single case methods (these will be covered in your research methods lectures). The aim is to demonstrate a systematic approach to monitoring client change over the course of intervention, with frequent, possibly session-by-session, applications of a simple quantitative measure of the client's behaviour or main problem.

Competencies to be demonstrated
The report allows you to demonstrate the ability to conceptualise and report on a piece of clinical work within the single case framework.

What the markers will be looking for
The markers will be assessing the ability to design, conduct and report on an intervention using single case methods.

Type of clinical material appropriate to this report
A clinical problem or situation where systematic monitoring of client change is integral to treatment planning or intervention. The report should focus on a behaviour that can be quantified and measured regularly (usually by self- or other- observation) and should involve the application of a defined intervention. There will usually be clearly delimited baseline and treatment phases. The single case method may be applied in terms of a classic ABAB design, or could use another approach.

Examples of suitable pieces of clinical work include a parent training intervention to reduce a behaviour problem in a 4-year old child, a staff intervention to reduce challenging behaviour in a day centre setting for adults with learning disabilities, the acquisition of new learning for a client in a rehabilitation setting, or the monitoring of session-by-session change in a client with OCD.

Suggested content and structure
- a brief introduction to the general problem being addressed, with a review of relevant literature;
- a description of the clinical background, relevant cultural and contextual considerations, the details of the intervention, and a rationale for and a description of the methods of measurement;
- an appropriately developed formulation;
- the results of the intervention, including a graph of the data (statistical analyses are not usually needed);
- a discussion of the outcomes. This should include some consideration of causality – i.e. a discussion which considers whether the intervention itself was responsible for any change in the client/system;
- reflection on points of learning, including the utility of this approach in relation to the clinical work as a whole.

Additional material
There are no specific requirements, but additional material may be presented in an appendix if required.

OPTIONAL REPORT 2: ADVANCED ASSESSMENT REPORT

Aims
The aim of this report is to present a detailed account of a complex assessment, relating the work undertaken to psychological theory and outlining the implications of the assessment for clinical intervention.

Competencies to be demonstrated
This report allows you to demonstrate competency in assessing a reasonably complex clinical scenario or presentation, integrating material from a range of sources and relating this to theoretical knowledge, showing a capacity to disconfirm possible explanations for presenting problems (or at least attempting to do so) as well as an ability to identify confirmatory evidence for any hypotheses.

Often – though not invariably - the assessment will be part of a multidisciplinary approach and so this report also allows you to demonstrate competency in working as part of a multidisciplinary team. The report allows you to show that you have been able to:

- find a way to focus on the necessary questions
- gather a suitable range of information
- interpret the results of the assessment
- distinguish between alternative “explanations” for the presentation
- provide feedback and clear recommendations to the client, client's family, referrer, and/or other colleagues, as appropriate.

Criteria for the report (type of material)
A very straightforward assessment would not be acceptable – for example, it would not be appropriate to report on a single session assessment using a WAIS to determine cognitive functioning in an individual who is already known to have a learning disability.

The emphasis here is on an assessment which distinguishes between a number of non-trivial alternative explanations for a clinical presentation. For example:

- assessment of a child who is performing very erratically at school, where the aim is to answer questions about the factors which could be contributing to this picture

- assessment of a client in a CMHT with a long and complicated psychiatric history, where the aim is to clarify the nature of their presentation and hence to identify a treatment plan

- assessment of a person who is referred for “anxiety” and who presents with such a wide range of anxiety symptoms that it unclear what type of intervention is most likely to be of benefit, and where the aim of assessment is to arrive at a formulation which can be used to guide a focused treatment plan

Many (but not all) assessments will be carried out over a number of sessions.

Where an assessment is conducted in the context of team working the assessment process can include information from a range of sources, and also involve seeking the views of a range of workers who have had contact with the client or their carers.

What the markers will be looking for

The markers will want to see a detailed understanding of the theoretical and clinical issues raised by the referral, and (if relevant) of the multidisciplinary or service context within which the assessment takes place. There should be:

- a clearly identified set of aims for the assessment. This should include a description of the specific challenges posed by the assessment question
- (as relevant to the piece of work) appropriate use and interpretation of measures
- a demonstration of your capacity to integrate information (for example, 'triangulating' information from different sources/ informants, or integrating assessment information)
- a psychologically-informed interpretation of results

Overall you should demonstrate that you can use the findings of the assessment to produce useful clinical recommendations, and show how these can be, or have been, acted on.

Suggested content and structure

The report should include:

- A brief introduction and account of the referral and presenting problem
- Aims of the assessment and a statement about the specific challenges posed by the assessment question
- An overview of any relevant theoretical literature.
- A rationale for the initial plan for the assessment, describing what questions you aimed to answer, and why, and detailing the various sources from which information was obtained.
- A description of the assessment process(es)
- An account of the information obtained and any pertinent observations made during the assessment(s), including relevant cultural and contextual considerations
- An integration of this information to provide likely answers to the questions posed and/or a comprehensive psychological formulation.
- A discussion of the clinical recommendations arising from the assessment, and how these were taken forward.
- A critical reflection on the work undertaken.

All advanced assessment reports should include a description of the ways in which findings from the assessment were used – this is as important a competency as the assessment itself. For example:

- how did you give feedback to the client and/or carers?
- how was information shared with the team and how was this received/acted on by them

Additional material

A brief description of any standardised or observational measures used, and a summary of the client's scores (raw scores and standard scores), should be included as appendices.

OPTIONAL REPORT 3: THEORY-ORIENTED REPORT

Aim
The aim of this report is to show familiarity with the complexities of a particular theoretical orientation or framework.

Competencies to be demonstrated
This report allows you to demonstrate the ability to draw on psychological theory, at a reasonably sophisticated level, to understand clients' clinical presentation and to inform your practice.

What the markers are looking for
The report will be evaluated in terms of the quality and sophistication of the theoretical framework which you are able to bring to the clinical issue you identify. The markers will therefore want to see that:

- you can use the theoretical ideas to explain important clinical observations
- you can use the theory appropriately
- evidence associated with the theory is appropriately considered in relation to the clinical material
- your understanding of the clinical material is deeper as a consequence of this theoretical consideration
- the limitations of the theory are accurately and appropriately identified

The presentation of the theory itself separately from its integration with the clinical material is not an important part of the assessment – in other words credit would not be given for descriptions of the theory that were not related to the clinical material.

Type of material
Any type of clinical work would be suitable and any kind of clinical problem could be the subject of the report.

Suggested content and structure
The report should briefly outline the theoretical framework to be used. If relevant to the material presented, it may be appropriate to identify any controversies concerning its status (for example, if the approach you adopted is not usually applied to the client group you are describing, or the evidence base for its use is very limited).

The report should start with a description of the client, relevant cultural and contextual considerations, and the clinical problem that is to be addressed. The main focus of the report should be an integrative discussion of how the chosen theory illuminates aspects of the clinical material – for example, the presentation, history, associated factors, the process of therapy or the outcome of intervention. They key word here is “integrative”, showing how theoretical ideas illuminate the clinical material and aid understanding, and the ways in which the theory helped the actual work.

The report should conclude with critical reflections, including points of learning. If there are aspects of the clinical material that are inconsistent with the theoretical formulation, this should be discussed and reflected upon, whether this reflects a concern with the application of the theory, or suggests limitations of the theoretical framework under consideration.

Additional material required
There are no specific requirements, but if necessary additional material may be presented in an appendix.

OPTIONAL REPORT 4: A COMPLETED CLINICAL INTERVENTION

Aim
This report offers an opportunity to discuss in detail a whole treatment - from planning to implementation, and hopefully to follow-up, highlighting the decisions made and steps taken. The aim is to give evidence of your clinical reasoning and it is particularly important to highlight your thinking about your work and the considerations which have led you to make specific choices at specific times.

Competencies to be demonstrated
The report allows you to demonstrate the ability to report clearly on your clinical work, describing the decision-making processes that you followed and the way in which these informed both the design of the intervention and its subsequent adaptation in the light of the client's response.

What the markers are looking for
The clinical report is evaluated on the basis, not of the success of the work undertaken, but of the clarity and coherence of reporting of clinical material. It gives you an opportunity to demonstrate your capacity to describe:
a) the process of clinical decision-making that leads to the design of a treatment intervention;
b) the ways in which this intervention is re-appraised and modified in the light of the client's response.

While it is important for you to demonstrate that your work was guided by a particular conceptual framework, the *detailed* presentation of that framework need not be part of the report. Evidence of knowledge of the framework is expected to be implied by the decision making process described. Evaluation will focus on the clarity of reporting of clinical experience, the level of clinical thinking (both prospective and retrospective) reflected in the report, and the appropriateness and sophistication of the clinical interventions described (including the capacity to respond to unexpected consequences of clinical decisions).

Type of material
Any clinical intervention, whatever its outcome, in which you have been involved throughout the whole process from assessment to follow up, should provide appropriate material for this kind of report.

Suggested content and structure
Normally the report will contain the following components, though the structure may vary somewhat, depending on the theoretical orientation of the report:

- Brief introduction and background to the referral
- Description of cultural and contextual considerations;
- Initial ideas and hypotheses concerning the presenting issues, and assessment procedures implemented to confirm these hypotheses
- Conclusions based on the assessment, and your initial formulation of the clinical presentation or presenting problems
- A detailed report of the intervention. If relevant, you should also describe any ways in which your thinking was modified as information emerged from the treatment – for example, how initial hypotheses were reframed or formulations revised.
- Brief report of outcome
- Reflection on the work as a whole

Normally the background information would be kept to a minimum and your clinical thinking both during and after the intervention would be given the most weight.

OPTIONAL REPORT 5: AN IMPASSE IN A PSYCHOLOGICAL INTERVENTION

Aim
The aim of this report is to focus on a piece of clinical work where there were significant difficulties in implementing an intervention. There are various dictionary definitions of an 'impasse' - for example, a situation that is so difficult that no progress can be made; a deadlock or a stalemate. The word ‘impassable’ is derived from the word impasse – to mean (for example) a road or passage having no obvious exit; like a cul-de-sac.

In the context of psychological interventions the word ‘impasse’ is used to indicate that a major obstacle has emerged which, if not addressed, could represent a major threat to the maintenance of therapeutic contact.

Examples of an impasse might be:
- a client who had been making good and steady progress who suddenly becomes angry and sullen for no reason that you can (initially) detect
- a client who has been attending regularly who starts missing sessions for no clear reason
- a client who readily agrees to carry out behavioural experiments in the session, but never carries them out in practice
- a client who says they can only continue if you are able to be a friend to them, rather than a therapist

Impasses are not simple perturbations in the therapy – for example a single incident where the client seems puzzled about something and you resolve matters very quickly. An impasse is usually a major impediment that could derail the therapy if not attended to.

Competencies to be demonstrated
The report allows you to demonstrate skills in managing impasses in clinical work, including the ability to recognise such situations as they arise, to use your theoretical knowledge and clinical experience to understand the possible reasons underlying these developments, to identify an appropriate course of action, and to reflect on the work undertaken.

What the markers are looking for
Because this report focuses on the management of impasses, a good report will demonstrate competence in the capacity to:
- recognise the presence of an obstacle to implementation of an intervention;
- draw on relevant academic and clinical knowledge in order to understand the nature of the problem, and to derive a working formulation of the issues;
- translate this formulation into a set of actions appropriate to the clinical context;
- articulate the above in a coherent and reflective manner, including any broader implications for clinical practice.

Type of material
Examples of relevant situations could include work where:
- major challenges to the therapeutic alliance emerged
- a client's complex social problems made the delivery of the psychological intervention problematic
- the client aroused strong personal feelings in you as therapist, with implications for your capacity to deliver the intervention
- indirect interventions were threatened by the antipathy of a staff team
- serious difficulties emerge in applying the theoretical model being adopted

Although many impasses emerge only when treatment is under way, reports could also cover instances where major obstacles to engagement had to be surmounted before an intervention could

begin, and where intervention based on an understanding of these obstacles was critical in sustaining contact. They could also consider situations where it becomes clear that difficulties in implementing an intervention indicated the need for a major revision in the approach taken.

Reports that discuss unresolved impasses will be as welcome as those where the impasse is overcome.

Suggested content and structure
This report will usually:

- provide a brief introduction;
- identify the nature of the impasse and review relevant clinical and theoretical literature;
- describe the clinical context within which the impasse developed;
- provide an account of relevant cultural and contextual considerations;
- offer a formulation or hypotheses about why the impasse has emerged;
- describe the ways in which resolution of the impasse was attempted; and
- provide critical reflections, including a consideration of the outcome and any further steps that may be recommended or proposed.

Additional material required
There are no specific requirements, but if necessary, additional material may be presented in an appendix.

OPTIONAL REPORT 6: INTER-PROFESSIONAL AND/OR INTER-AGENCY WORKING

Aims
The aim of this report is to present a detailed account of an intervention where work with individuals from other professionals was central, or played a significant role in the intervention.

Criteria for the report (type of material)
It is important to choose a piece of work where inter-professional or inter-agency working was important, rather than incidental, to the work, and where there is sufficient material to explore the ways in which the interdisciplinary nature of the work influenced progress.
The work may have involved close liaison with other professionals in a multi-disciplinary team, with several professionals actively contributing to work with an individual client, or may have involved working across different agencies (for example, with workers based in different statutory settings. Reports could of course encompass both inter-professional and inter-agency working.

Competencies to be demonstrated
This report allows you to demonstrate competency in inter-professional or inter-agency working, showing an awareness of common challenges to, and benefits of, this way of working (for example, because of differences in staff roles, assumptions and values), and identifying the impact of this way of working (for good or ill).

The report allows you to show that you have been able to:
- understand the roles and hence potential contributions of other professionals, drawing on this knowledge to work as effectively as possible with colleagues in the interests of the client
- identify and work with any legal and professional issues that arise in the course of the work (for example, around confidentiality and information governance)
- assess (and formulate) the reasons for any barriers to effective work
- identify any strategies used/implemented in order to manage the work/ mitigate any barriers to effective working
- contribute to the team or to the work of other agencies through verbal and/or written communications

What the markers are looking for
The markers will want to see a detailed understanding of any theoretical, clinical and professional issues raised by the multidisciplinary or service context within which the work takes place. There should be:
- a clear description of the service context(s) and the professionals involved in the work (in other words, the 'system' within which the intervention is taking place)
- a demonstration of your capacity to integrate information (for example, 'triangulating' information from different sources/ informants, or integrating assessment information)
- a demonstration of your contribution to the work of other professionals/agencies

Suggested content and structure
The report should include:
- a brief introduction
- an account of the context for the work, including the referral (or the 'route' taken by the client such that they are being looked after by the team)
- an account of cultural and contextual considerations that informed the work

- a description of the clinical work being undertaken (describing the nature of the client's problems and the approach the service is taking towards them),), including a clear account of your role and contribution to the work
- a description of the formal (and informal) relationships between the professionals involved in the clinical work
- a description of the ways in which the team or agencies formulated the problem and the actions required to manage these (including differences of view)
- an account of the way that the work developed and the roles different professionals played in its execution
- a description of how the functioning of the inter-professional/ inter-agency system promoted or impeded the efficacy of the work
- a description of how the clinical work progressed and any outcomes from this work
- a critical reflection on the work undertaken.

OPTIONAL REPORT 7: A REPORT OF A CONSULTATION WITH EXPERTS BY EXPEREINCE/CARERS[2]

Aims
The aim of this report is to present a detailed account of a consultation with experts by experience (who could be direct consumers of health care, carers, or representatives from expert by experience/service user/carer organisations).

The experts by experience who are consulted should not be recipients of direct clinical services provided by the trainee.

Competencies to be demonstrated
This report allows you to demonstrate competency in setting up a consultation with experts by experience that promotes respectful engagement and learning from them, while helping you to understand the issues and values that are important to them, and the implications of these for service delivery and service development.

The report allows you to show that you have been able to:
- set up a consultation designed to help you and your service understand the perspectives of experts by experience, and that enables experts by experience to present their ideas as experts and/or equal stakeholders
- implement and facilitate a collaborative discussion
- derive a coherent account of the perspectives and values of experts by experience
- relate the 'position' of the experts by experience to the viewpoint/assumptions of the professional 'system' within which service users are being seen, and formulate reasons for any differences
- reflect on and apply any conclusions/implications from the consultation to your own practice as well as that of the professional service
- where relevant, disseminate insights/ information from the consultation to the service in a professional and constructive manner

Criteria for the report (type of material)
It is a good idea to choose consultations where contact with experts by experience/service users or carers has been meaningful, for example because it has contributed to a better understanding of service needs and service delivery, or has implications for service redesign (which could mean small but meaningful adjustments as well as suggestions for more significant change).

What the markers are looking for
The markers will want to see a detailed understanding of any theoretical, clinical and professional issues raised by the consultation. They will also be looking for:
- an account of the rationale for, and purpose of, the consultation
- a description of how the consultation was set up, along with its format and content
- any 'insights' gained as a result of the consultation and how these might be taken forward/ disseminated

Suggested content and structure
The report should include:
- a brief introduction
- a description of the service context
- a description of cultural and contextual considerations
- a description of the issues that prompted the consultation
- a description of the way the piece of work has been conceptualised

[2] Course expectations regarding service user consultations are detailed in the Training Handbook

- a description of how the consultation was set up (including any relevant correspondence), and the rationale for the approach taken
- a description of the ways in which relevant 'ground rules' were negotiated with the experts by experience (e.g. around confidentiality, or the way in which feedback would be given)
- a description of the procedures used to garner information, including any systematic procedures
- a description of the conclusions drawn from the consultation
- a description of the process of giving feedback from the consultation (both to experts by experience as well as the service)
- if relevant, an account of any planned changes made on the basis of the consultation
- if relevant, any formal/informal evaluation of the impact of these changes
- reflections on the consultation process

Where relevant the report should also describe any changes in service delivery/service design consequent on the consultation.

OPTIONAL REPORT 8: A REPORT OF A PIECE OF 'LEADERSHIP' WORK

Aims
The aim of this report is to present a detailed account of a piece of leadership work, which may be conducted within teams or organisations.

Competencies to be demonstrated
This report allows you to demonstrate competencies in a range of areas, depending upon the context in which you are working. This would be very different in a policy context and a managerial/business context, or an NHS or social enterprise context, for example.

The report allows you to show that you have been able to implement at least some of the following leadership competencies (you will not be expected to demonstrate ALL of the following - markers will use their judgement as to which are most relevant to the piece of work you are presenting):

- identify the contexts for change
- demonstrate awareness of the political, social, technical, economic, organisational and professional environment
- understand and interpret relevant legislation, accountability frameworks, policy, and existing evidence
- anticipate and prepare for the future by consulting key stakeholders regarding ideas, best practice, and/or emerging trends that will have an impact on the key outcomes for the team/organisation
- use appropriate methods to gather information
- influence others to use knowledge and evidence to achieve best practice
- use information to challenge existing practices and processes
- participate in and contribute to organisational decision-making processes
- educate and inform key people who influence and make decisions
- contribute a psychological perspective to team, department, system and organisational decisions
- identify barriers and to implementation and potential solutions
- formally and/or informally disseminate good practice
- recognise and articulate your own values and principles, understanding how these may be different from those of others
- identify your own strengths and limitations, and the impact of these on others

The above list is not an exhaustive list of leadership competencies. For further information on competencies that may form part of this report, please see the Clinical Psychology Leadership Development Framework (DCP, 2010).

Criteria for the report (type of material)
Examples of relevant work could be:

- arriving in a new team and conducting a scoping exercise on their needs, proposing a within-service change, negotiating this with key stakeholders and carrying it forward (or how this was left upon departure from the service so that it could be taken forward)
- taking forward an initiative proposed by a supervisor or senior figure within the organisation, including how you assessed its relevance, researched and/or negotiated it within the team, and carried it forward
- setting up an initiative relevant to the work of clinical psychologists or the client groups served by clinical psychologists (inside or outside of placement)

If the report is written on work carried out as part of training but outside of a placement context (e.g. work for the doctoral training programme), it can be signed off by another qualified psychologist who can verify the work.

What the markers are looking for
The markers will want to see a detailed understanding of any theoretical, clinical, professional and policy issues raised by the piece of work. They will also be looking for:

- an account of the rationale for, and purpose of, the piece of work
- a description of how the work was set up, along with its format and content
- any 'insights' gained as a result of the work and how these might be taken forward/ disseminated

The work does not need to be 'perfect'. Indeed, much can be learned from apparent 'mistakes' and the identification and overcoming of obstacles, and this can be reflected upon in the account.

Suggested content and structure
The report should include:

- a description of the organisation and/or policy context
- a description of the issues that prompted the work
- a description of how the piece of work was set up (including any relevant correspondence), and the rationale for the approach taken
- a description of the ways in which relevant 'ground rules' were negotiated with the participating individuals and/or organisations (e.g. around confidentiality, or the way in which feedback would be given)
- a description of the procedures used to garner information, including any systematic procedures
- a description of the conclusions drawn from the work
- a description of the process of disseminating insights arising from the work
- if relevant, an account of any planned changes made on the basis of the work
- if relevant, any formal/informal evaluation of the impact of these changes
- reflections on the process

Where relevant the report should also describe any changes in service delivery/design, organisational change, and/or policy consequent on the piece of work.

You may draw upon a variety of theoretical material which includes but is not limited to:

- clinical models and methods applied in organisational contexts
- organisational psychology
- management and economics texts