



Improving Access to Psychological Therapies

Postgraduate Diploma in High Intensity Psychological Interventions

Practice Portfolio: Structure and Guidance

March 2021

Function and Content

The function of the Practice Portfolio is to direct and support HIPI trainees in recording and demonstrating their development and achievement of the Roth and Pilling CBT clinical competencies. Please see the link below to ensure that you know what these competencies comprise of:

<https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-2>

The portfolio is submitted on **TWO** occasions in order to review trainees' development and achievement of the clinical competences, professionalism, fitness to practise and general clinical progression over the course of the year. You will receive written feedback after the interim submission from the marker following an Internal Exam Board. The Practice Portfolio forms an integral aspect of all three modules and must be passed for the trainee to pass the HIPI course. As per the Course Handbook, a trainee will be allowed (under normal circumstances) to resubmit the Interim Practice Portfolio on one further occasion, if the first submission is considered as a fail at an Exam Board. As per the Course Handbook, a trainee will be allowed (under normal circumstances) to resubmit the Final Practice Portfolio on one further occasion, if the first submission is considered as a fail at an Exam Board. The grades for the Practice Portfolio on each submission are either PASS, FAIL or PASS Pending as awarded by an Internal Exam Board.

Practice Portfolio extensions

If an extension is required on a specific section of the portfolio, the trainee must clearly identify the section they need more time on and why when completing an extension request form. **If an extension is granted, it is for the specified section only.** The trainee must submit the Practice Portfolio by the assessment deadline, with a note added to the supplementary documents section to identify to the marker that an extension has been granted. If any element of the portfolio is excluded for which an extension has not been granted, the trainee will receive a FAIL mark. A PASS pending is awarded if all elements submitted are acceptable but there are outstanding elements on extended deadlines.

At each submission point the trainee is required to collate the relevant information and ensure that the service and group clinical supervisor has completed the relevant report (the structure for these submissions by the supervisors are in this document and in the Supervisor's Handbook). It is the trainee's responsibility to ensure that the clinical supervisor's reports are submitted on time and in sufficient detail.

The Practice Portfolio needs to be completed contemporaneously throughout the year. For example, the case flow chart needs to be updated on a weekly basis so that it is an accurate portrayal of clinical practice. The dates for submission are in the Course Handbook. Please submit your Practice Portfolio to the PebblePad by 1.30pm on the indicated dates.

Please note the following:

- a) The portfolio **MUST** be submitted via PebblePad
- b) Ensure that all client and service information is completely anonymised - if this is not done a fail grade will be issued.
- c) The Practice Portfolio captures in detail the CBT work completed with 8 focused cases in detail and also records all clinical activity conducted during the year.
- d) That client 'identifiers' (e.g. client 1) are consistent throughout the document so the case can be tracked through the Practice Portfolio. Therefore, client 1 (if it is one of the 8 in detail cases) will have an assessment letter, treatment plan, formulation, patient summary and end of treatment report that are clearly identifiable as pertaining to the patient.
- e) **The trainee needs to demonstrate working across the diagnostic categories in the Practice Portfolio. Therefore, to ensure spread of clinical work in the 8 focussed cases, there needs to be a maximum of 3 cases of any one single diagnosis. One of the 8 cases MUST be a PTSD case.**
- f) In terms of depression, it is possible to have 4 cases but, if so, these need to be split evenly between CT and BA formulations.
- g) One of the supervisor rated CTS-Rs needs to be rated >36 (pass).

What needs to be in the Mid-Point Practice Portfolio submission?

- a) 100 hours' clinical contact (achievement/good progression towards it)
- b) Case flow chart of all clinical activity to date
- c) 4 patients for a reasonable trial (5 sessions) of the evidence-based CBT treatment, using an appropriate model evidenced by inclusion of 4 patient summaries
- d) 4 assessment reports
- e) 4 formulations
- f) 4 treatment plans
- g) 4 relapse prevention plans (if treatment completed)
- h) Two end of treatment reports (if treatment completed)
- i) Signed clinical supervision contracts (service and university)
- j) Signed clinical supervision logs- service and university
- k) Log of 40 hours' clinical supervision (achievement/progression)
- l) Log of 'close' supervision
- m) Record of 3 sessions shadowing - 3 assessment sessions
- n) Two CTS-R self-rated sessions and reflections
- o) One CTS-R service supervisor rated session and reflection either anxiety or depression or transdiagnostic. Cannot be a reflection on either of the CTSRs from the formative days.

- p) One formative CTS-r from University group supervision (Anxiety or depression)
- q) One case summary (either anxiety or depression or transdiagnostic- see details)
- r) Reflection (1000 words) on therapeutic dynamics based on OSCE actor feedback
- s) Ongoing reflective journal - at least one completed reflection
- t) Service supervisor interim report
- u) Group supervisor interim report
- v) Service supervisor statement of achievement
- w) Group supervisor statement of achievement/engagement
- x) SP/SR facilitator statement of engagement in SP/SR
- y) Catch up forms if any University sessions missed
- z) BABCP membership number

*****If you are likely to fall short of the criteria for mid-point submission this must be raised with the teaching team as soon as possible so that a plan can be put in place to support you to complete the course on time*****

What needs to be in the Final Practice Portfolio submission?

- a) 200 hours' CBT face to face clinical contact
- b) Case flow chart of all clinical activity and summary of clinical hours
- c) Outcome monitoring (change rates, Jacobson plots, effects sizes and associated reflection)
- d) 8 patients for a reasonable trial (5 sessions) of the evidence-based CBT treatment, using an appropriate model evidenced by 8 patient summaries. One of these must be a PTSD case.
- e) 8 assessment reports
- f) 8 formulations
- g) 8 treatment plans
- h) 8 end of treatment reports
- i) 8 patient summary sheets
- j) 8 relapse prevention plans
- k) Signed supervision contracts, both university and service
- l) Documented clinical supervision in service and university
- m) Log of 70 hours clinical supervision (5 hours minimum per each of the 8 cases, using the formula)
- n) Log of 3 hours of close supervision on at least 3 of the 8 cases. One of these must be a PTSD case.
- o) Record of 6 sessions shadowing - 3 assessments and 3 treatments
- p) 4 CTS-R self-rated sessions and two 1,000 word reflections
- q) 2 CTS-R service supervisor rated sessions (one scored ≥ 36) and two associated 1,000 word reflections (one must be an anxiety treatment session and the other a depression session - or one but not both can be a transdiagnostic case) cannot be a reflection on the CTSR completed on either of the formative days. One must pass.

- r) Two formative CTS-r's from University Group supervision (one anxiety treatment session and one depression treatment session) - please note that these need to be different sessions from the passed service supervisor rated session in section q.
- s) 2 case summaries (2,000 words) one anxiety and one depression (or one of the two may be a transdiagnostic) focussing on disorder-specific and alliance-specific outcomes
- t) Reflection (1000 words) on therapeutic dynamics based on OSCE actor feedback
- u) Reflective journal (3000-4500 words)
- v) Service supervisor interim report and interim statement of achievement
- w) Group supervisor interim report and interim statement of achievement
- x) Service supervisor final report
- y) Group supervisor final report
- z) Service supervisor final statement of achievement
- aa) Group supervisor final statement of achievement
- bb) SP/SR engagement statement and SP/SR records
- cc) Completed necessary catch-up forms
- dd) BABCP membership number

Definition of the 8 “training cases”

- a) Treatment completed (or a reasonable trial of treatment) using the appropriate disorder specific IAPT model
- b) Number of sessions delivered being appropriate to the model
- c) Received five hours' clinical supervision on each case
- d) Received 'close' (live or recorded) supervision of at least three hours on at least three of the training cases, one of these cases **MUST** be a PTSD case
- e) Include a minimum of three different presentations, one of which **MUST** be PTSD
- f) The cases must include two clients treated for depression, a minimum of one treated using a BA model and a minimum of one treated using Cognitive Therapy
- g) Used NICE guided models where available
- h) Treatment of IAPT step 3 appropriate cases
- i) Use of a transdiagnostic protocol (the UP) on one training case of the eight is possible
- j) Must not contain a 'low self-esteem' case
- k) Must not use the same model for treating depression for more than two of training cases
- l) Must not use transdiagnostic model for more than one of the 8 cases

PebblePad

The Practice Portfolio is submitted on Pebblepad which can be accessed via BlackBoard. In the resources section on Blackboard you will find detailed instructions about how to access Pebblepad and submit your work using this platform.

If you would like to continue using Pebblepad once you have finished the course, then you can create an alumni account which enables to keep all the documents you have created. The details on how to do this are here:

<https://www.sheffield.ac.uk/apse/digital/pebblepad/alumni>

The following elements must be completed and submitted on Pebblepad within the sections provided:

Case Flow Chart

A template is found on PebblePad.

Calculating caseload change rates

Recovery in IAPT is measured in terms of clinically significant illness presentation often referred to as 'caseness.' The term 'caseness' refers to when a patient has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were defined as a clinical case at the start of their treatment ('at caseness') and not as a clinical case at the end of their treatment, measured by scores from questionnaires tailored to their specific condition. Caseness on the PHQ-9 is a score equal to or greater than 10. Caseness on the GAD-7 is a score equal to or greater than 8.

In addition to recovery, there are two other measures of outcome in IAPT: reliable improvement/deterioration and reliable recovery. A referral has shown reliable improvement or deterioration if there is a significant improvement or deterioration in their condition following a course of treatment, measured by the difference between their first and last scores on questionnaires tailored to their specific condition. The reliable change index on the PHQ-9 is a score that changes by more than 6 points between first and last measurement point. The reliable change index on the GAD-7 is a score that changes by more than 4 points between first and last measurement point.

A referral has reliably recovered if they meet the criteria for both the recovery and reliable improvement. That is, they have moved from being a clinical case at the start of treatment to not being a clinical case at the end of treatment, and there has also been a significant improvement in their condition.

Depression cases recovery rate on the PHQ-9=

Anxiety cases recovery rate on the GAD-7 =
Depression cases reliable improvement rate on the PHQ-9 =
Anxiety cases reliable improvement rate on the GAD-7 =
Depression cases reliable deterioration rate on the PHQ-9 =
Anxiety cases reliable deterioration rate on the GAD-7 =
Depression cases reliable recovery rate =
Anxiety cases reliable recovery rate =
Depression effect size (and interpretation) =
Anxiety effect size (and interpretation) =

Disorder-specific Jacobson Plots

One of the aims of the course is that CBT trainees learn to appreciate the value of patient feedback in terms of clinical outcomes and also be able to understand and reflect upon the outcomes they are facilitating. Trainees need to produce two Jacobson plots - one for all their work with patients presenting with depression (regardless of whether they finished treatment) and one for anxiety (regardless of whether they finished treatment). All patients that have had more than one session on the case flow chart will be included in these plots. Those patients who completed treatment need to be represented with a green circle and those who dropped out with a red circle on each Jacobson plot. The Jacobson graphs on which to plot the outcomes are included on Blackboard along with a worked example you can use as a guide and teaching is provided on how to produce and interpret the plots.

Disorder-specific effect size calculations

Trainees are expected to calculate a disorder specific effect size for all cases they have seen in the training year that have two measurement points (first and last).

The depression cases instructions for this are as follows:

1. Identify your depression cases.
2. Calculate the mean (M1) and standard deviation (SD) for the first score
<https://www.calculatorsoup.com/calculators/statistics/standard-deviation-calculator.php>
3. Calculate the mean for final scores (M2).
4. Minus the second score from the first score and divide by the standard deviation of the first score (i.e. $M1 - M2$ divided by SD of M1)
5. Report the effect size

The anxiety cases instructions for this are as follows:

1. Identify your anxiety cases.

2. Calculate the mean (M1) and standard deviation (SD) for the first score
<https://www.calculatorsoup.com/calculators/statistics/standard-deviation-calculator.php>
3. Calculate the mean for final scores (M2).
4. Minus the second score from the first score and divide by the standard deviation of the first score (i.e. $M1 - M2$ divided by SD of M1)
5. Report the effect size

Reflection on the use of outcome monitoring

Trainees are required to submit a 1,000-word reflection on the Jacobson plots, effect size calculations and also the clinical process of outcome monitoring with their patients. This needs to be structured with a reflective model.

CBT Assessment Reports

A minimum of 8 assessment reports are required. The assessment report should include all the relevant information that the referrer needs in terms of general case description, relevant history, presenting problem, probable diagnosis, risk, interpreted IAPT MDS scores, treatment targets and actions relevant to the report (e.g. how many sessions are planned).

The assessment reports should not contain ANY information that identifies the patient, the trainee, the referrer or the service.

Clinical CBT Formulations

A minimum of 8 word processed case formulations are required. Formulations should have high fidelity to the models in the CBT competency framework, with relevant patient centred ideographic detail included. Each formulation needs the model reference appended at the bottom and it be clear as to which patient it pertains to from the case flow chart.

CBT Treatment Plans

A minimum 8 CBT treatment plans are required. The treatment plans should demonstrate how the CBT therapy that is planned matches the relevant and referenced treatment protocol in the CBT competency framework. Patient centred information should be integrated into the treatment plan and drawn from the formulation - for example the type of behavioural experiment planned and which belief is being tested.

Discharge Reports

A minimum 8 discharge reports are required. These reports should contain a summary of the CBT work completed in terms of the patient engagement, record of attendance, achievement of goals, interpreted clinical outcomes scores, any out-standing risk issues and any further actions including possible follow-ups.

The discharge reports should not contain ANY information that identifies the patient, the trainee, the referrer or the service.

Relapse prevention planning

For the 8 training cases (where treatment has been completed), the (anonymised) relapse prevention work (e.g. therapy blueprint) completed with the patient needs to be included. Please note that if the focussed case does not finish treatment, the 8 required relapse prevention plans can be supplemented with the relapse prevention plan from another patient provided it uses the same treatment (eg CT for depression). If not suitable alternative is available then the trainee can submit a relapse plan that would reflect a course of treatment using that modality. This is to ensure that there are 8 plans in total. Please be sure to recognise clearly when separate relapse prevention plans are being submitted and highlight any substitutions.

Patient Summaries (for the 8 focussed cases)

Templates can be found on PebblePad.

Record of close supervision (for the 8 focussed cases)

For **each** of the 8 focussed cases there needs to be evidence of **5 hours** of clinical supervision on those cases. The minimum standard for live supervision of the 8 cases is that **for 3 of the 8 cases**, there needs to be evidence of **3 hours of close supervision**. One of these 3 cases **MUST** be a PTSD case. Of course, close supervision counts towards the overall supervision total time (i.e. it is counted twice). Close supervision is defined as your supervisor sitting in on a session or watching a recording of your work. The CTS-R is expected to be used to assess competency during any close supervision.

Please complete the required table on PebblePad.

Shadowing

Shadowing refers to observing the practice of another experienced CBT colleague in your service. This is helpful as it allows trainees to develop a sense of what a 'good enough' assessment and treatment sessions looks like. Trainees are required to shadow at least three assessment sessions by the mid-term portfolio submission and an additional minimum three treatment sessions by the final portfolio submission. Shadowing can take the form of watching a recording of sessions. The 'shadowing record form' below should be completed on each occasion.

Supervision Contract

The trainee is required to provide copies of the signed supervision contracts for both University group supervision and also individual supervision with the service supervisor. Bespoke contracts are encouraged that take account of learning styles and necessary accommodation of any disabilities. It is suggested that supervision contracts contain the following information, as a basic:

- The formal time and frequency of supervision
- Agreement on the boundaries of confidentiality
- How and whether informal contact is accepted
- How the reflective space of supervision will be ensured
- What the focus of the supervision will be (e.g. casework, theory, technique)
- The supervisory methods to be used (e.g. modelling, role play, etc.)
- Degree and regularity of feedback
- How support for theory practice links will be ensured
- How caseload size and range will be agreed
- Frequency of live supervision and associated method feedback
- Facilities for observation of trainee practice
- Practical issues, e.g. travel, personal needs, etc.
- Making clear the unsaid expectations of supervisor
- How fluidity and ruptures in the supervisory relationship can be identified, negotiated and resolved

Clinical Supervision Session Record

Please complete weekly supervision logs and ensure your supervisor adds their signature and comments. These should then be collated and uploaded in one document for PebblePad.

Record of Group/Individual Clinical Supervision						
Supervisee:						
Supervisor:						
Date:						
Client details		Supervision issues and/or questions	Supervision notes	Agreed actions	Time spent of case	
Initials						
Disorder						
No. of completed sessions in the contract						
Session 1 IAPT scores						
Current IAPT scores						
Supervisee reflections, e.g. theoretical, clinical and/or personal learning plan			Supervisor comments			

Supervision method* (please underline)	
<ul style="list-style-type: none"> *individual case discussion *case management *theory development *direct observation *feedback on audio/visual recording *use of CTS-R *role play/rehearsal 	
Supervisor signature:	Supervisee signature:

Self-rated treatment sessions using the CTS-R

Trainees need to submit **four examples** of using the Cognitive Therapy Scale - Revised (CTS-R) on their own CBT practice. The 4 CTS-Rs need to be from 4 separate cases (they need not be taken from the 8 focussed cases). The CTS-Rs in the Practice Portfolio cannot be the session used for summative assessment in the CBT for Anxiety or CBT for Depression modules. Each self-rated CTS-R needs to have the formulation for the patient attached and the session number in the contract clearly stated. One of the self-rated CTS-Rs needs to be a depression treatment case. The sessions cannot be screening, assessment or final review sessions. **Two** of the trainee-rated CTS-R needs to include a reflective analysis of **1,000 words**, which is appropriately referenced to relevant CBT theory and evidence and in which the use of an established reflective model is clearly evident.

Service Supervisor-rated treatment sessions using the CTS-R

Two sessions need to be rated by the service clinical supervisor using the Cognitive Therapy Scale Revised (CTS-R). One session must pass. The two sessions cannot be taken from the same patient. The passed session must be different from the cases used for the therapy tape submissions but can be any of the case study patients. One session needs to be depression (either BA or CT as an opposite according to whether BA or CT was used in the self-assessed CTS-R sessions). Sessions cannot be the same self-rated sessions by the trainee. *Both CTS-R's are required to be of treatment sessions (not screening, assessment, review or final sessions).* *One session needs to attain a CTS-R score >36, with a score of 3 on the change method and at least 2 on the other items.* Each service supervisor-rated CTS-R needs to have the formulation for the patient attached and the session number in the contract clearly stated. Each service supervisor-rated CTS-R needs to include a reflective analysis of **1,000 words**, which is appropriately referenced to relevant CBT theory and evidence and in which the use of an established reflective model is clearly evident.

Formative CTS-R from University Group supervision

Two sessions will be rated for each trainee as part of timetabled group supervision. These are formative feedback marks provided by the supervisor and supervision group. Trainees must present one anxiety and one depression case for formative CTS-R feedback during the year. The two CTS-r feedback forms from the group supervisor do not need to pass. They are included in the Practice Portfolio and are additions to the Service Supervisor Rated sessions.

Case Summary Guidelines

Overview

You are required to provide a summary of TWO training cases that you have treated during your training year in the Practice Portfolio. The format of a case summary is similar to the case studies in the Anxiety and Depression modules, but the word limit is 2000 words and therefore brevity is important.

Case Summary 1 must include a focus in the reflection section on cultural considerations and cultural competency.

Case summary 2 must include a focus in the reflection section on the therapeutic alliance and the therapeutic process.

One of the cases needs to be a depression case and one an anxiety case or a comorbid transdiagnostic case. The trainee can choose whether to use their Depression case for case summary 1 or 2 and vice versa with respect to the anxiety case.

You must demonstrate that you have provided an 'adequate' course of therapy (i.e. minimum of six sessions contact with the patient) and reflected and learnt from your work with the case. The summary needs to include assessment information, formulation(s), an outline of treatment undertaken, examples of work completed by the client, clinical outcomes and a reflection on the case including student self-reflection. The case summaries are not awarded an individual academic mark, but are an integral aspect of your Practice Portfolio; the case summary will be reviewed and must reach a satisfactory standard.

Please note that one of the main aims of the case studies in the Practice Portfolio is for trainees to show awareness and use of disorder-specific and alliance-specific measures with their patients. Therefore, please ensure that the cases have a disorder specific measure (e.g. the Penn State Worry Questionnaire) and the Working Alliance Inventory - Short Form (WAI) (available on Blackboard) used on at least two occasions to enable comparisons. Both the patient and therapist sections of the WAI must be included. Please do not submit a case study in the Practice Portfolio that does not have a disorder and alliance specific measures. Case studies that do not use these measures will be failed.

You will be advised if you need to make any amendments to the case summary when the Practice Portfolio is marked. Therefore, it is useful to submit one of the case summaries with the Interim Practice Portfolio. On rare occasions a case may not be acceptable as a training case, you could be asked to find a replacement training case for example if you have not delivered an adequate course of therapy.

What is being assessed?

The case summary has a specific emphasis on your CBT treatment skills and disorder specific CBT competences and specifically being assessed are:

- Planning and delivering individualised and formulation-driven CBT
- Selecting and sequencing interventions according to treatment protocols demonstrating an adequate course of therapy has been undertaken
- Examples of interventions carried out in session and as homework
- Evaluation of and reflection on therapy outcome, showing ability to learn from experience
- Clarity and coherence of thinking
- Clear and concise presentation of information

When to write up a case summary

Generally, the CBT should be a full treatment and completed by the time the case is written up as a case summary. If you intend to submit an incomplete case (i.e. on-going or dropped-out), there must be a good reason and an account of this must form part of the submission. Where CBT is ongoing you will need to amend your summary once therapy has ended to include information on the remainder of your work with the patient and make some further reflection on your overall learning from the case. A good case summary does not require a successful outcome (i.e. the patient does not have to be “better” at the time of writing).

What case to choose?

It can be the cases that you have previously used for the Case-Based Literature Review or Formulation Case Study, but with a greater emphasis on treatment delivery (i.e. they can be taken from the 8-focussed cases). It cannot be cases submitted in the Anxiety or Depression modules as case studies.

Word count

The case summary should be 2000 words. Part of becoming a competent CBT therapist is to be able to write up specific and succinct accounts of cases, so this is a good skill to learn for your future practice. The focus is on treatment issues. Therefore, it useful to leave 1,250 words free approximately for the treatment, outcome and review sections.

Content and Structure of Case Summary

1. Introduction

Give a brief introduction to the patient, including:

- a) Brief basic biographical data: age, sex, gender and preferred pro noun, marital status, work, housing and family circumstances, sexuality, disability, ethnicity, religion, cultural background.

- b) Ensure personal details are altered so as not to breach confidentiality.
Please give the patient a name (not initials or a number), but make sure it is a pseudonym.

2. Presenting problem(s)

Please give an overview of the patients presenting problems including:

- a) Main current problems
- b) Any co-morbidity
- c) Reason for referral (why now?)
- d) Diagnosis - show how the patient meets diagnostic criteria, and whether other diagnoses were considered or excluded.
- e) Onset and development of the problem (for depression please outline if previous episodes)
- f) Previous treatment
- g) Current medication
- h) Risk assessment

3. Measures used and pre-treatment scores

This section should include:

- a) Use of a range of measures, including standard IAPT questionnaires and disorder-specific and alliance-specific measures.
- b) Idiosyncratic or individualised measures can also be used (e.g. ratings of problem intensity, degree of belief in particular cognitions).
- c) The patients initial scores on each measure (this is best presented in table form). Please present subscale scores as well as totals where relevant (e.g. OCI subscales)
- d) Discussion/interpretation of the meaning/clinical significance of scores (e.g. whether a particular score indicates mild, moderate or severe symptoms of depression).
- e) The patients therapy goals: make these SMART, consider using short, medium and long term goals, and a rating of progress towards goals

4. Case conceptualisation

This section should include an appropriate diagrammatic formulation and a brief narrative description.

- a) Depression: please present a BA or Beckian formulation
- b) Anxiety Disorders: use a disorder specific formulation (e.g. the Ehlers and Clark PTSD model). You may include a longitudinal element to the formulation in diagrammatic form where relevant and appropriate.
- c) In some anxiety disorders (e.g. Panic Disorder, Specific Phobias) it is not always necessary to develop a longitudinal formulation - if this is the case, make sure you include some written description about the onset, development and course of the problem.
- d) Give references for the formulations used

- e) Include any modifications made to the original formulation during therapy.
- f) Include consideration given to possible adaptations during the process of formulation to meet cultural or ethical factors

5. Course of therapy

This section should include:

- a) The aims/purpose of therapy
- b) Sufficient detail about your interventions (e.g. rather than saying “updated hotspots”, describe what hot spot was updated, how, and what the outcome was), so as to show what you did clearly, but avoiding a verbatim/overly inclusive account (which can inadvertently obscure what you did).
- c) Appendices showing examples of in-session work and homework (e.g. copies of completed activity monitoring diaries, behavioural experiment sheets, thought records).
- d) Include consideration given to possible adaptations during the process of treatment to meet cultural or ethical factors
- e) Evidence of a planned ending phase, how you prepared for discharge, and a copy of or summary of the therapy blueprint in the Appendix.
- f) Describe any difficulties in the course of therapy. Show how you thought about these in relation to the formulation and how you addressed them in therapy.

6. Outcome

- a) Describe and evaluate the outcome of treatment
- b) Include changes in the main problems originally identified, progress towards goals, changes in belief in key cognitions, whether the patient still meets diagnostic criteria, and impact of change on them.
- c) Use tables to show changes in IAPT MDS measures, week by week (add graphs in addition to tables if this helps).
- d) Discuss/interpret the meaning/clinical significance of end of treatment scores. Look at and discuss the pattern of change in scores across therapy - e.g. a week when there was a sudden drop or an unexpected increase in scores.
- e) Analysis and interpretation of disorder and alliance specific measures

6. Discussion/review

Reflection for Case Summary 1 should include a particular focus on cultural competency.

Please consider:

- a) Use of a reflective model

- b) Thoughts on your overall understanding and management of this case
- c) Reflections on the therapy relationship, what you made of the client, how you felt/what you experienced when working with them
- d) Consideration of cultural factors and context
- e) Consideration given to possible adaptations during the process of formulation/treatment to meet cultural factors
- f) Reflection of how the therapist own cultural norms may impact on the process of therapy
- g) Any changes to the original formulation and treatment plan
- h) Factors in the patient, yourself, and therapy which you believe contributed to success. What was the most successful change intervention?
- i) Reasons for lack of success (again, factors in the patient, yourself and therapy) and suggest how you might have handled the case differently, given the benefit of hindsight.
- j) Even if outcome was successful, do reflect on what you might have done differently, or what you might have done more of and why
- k) What you learned from treating this case. and how you will take this forward in the future
- l) Use of supervision

Reflection for Case Summary 2 should include a focus on the therapeutic alliance and therapy process.

Please consider:

- a) Use of a reflective model
- b) Thoughts on your overall understanding and management of this case
- c) Reflections on the therapy relationship, what you made of the client, how you felt/what you experienced when working with them
- d) Any changes to the original formulation and treatment plan
- e) Factors in the patient, yourself, and therapy which you believe contributed to success. What was the most successful change intervention?
- f) Reasons for lack of success (again, factors in the patient, yourself and therapy) and suggest how you might have handled the case differently, given the benefit of hindsight.
- g) Even if outcome was successful, do reflect on what you might have done differently, or what you might have done more of and why
- h) Consideration of ruptures or interpersonal problems were understood and managed
- i) Reference to the WAI
- j) Use of supervision

What you learned from

Include a brief reference list for the case summary and in the case summary refer to the relevant literature. Relate your discussion/reflection to the literature by citing authors in the text.

8. Appendices

Put the treatment plan in the Appendix. Also include examples of in-session work and homework for example copies of completed activity monitoring diaries, behavioural experiment sheets, thought records and the therapy blueprint. The Appendices and references do not count towards the word count. Everything else does.

Catch-up forms

If any teaching session is missed, a signed catch-up form is required. The form is available on PebblePad.

Reflection on OSCE actor feedback

This section will include the 1,000-word reflection written following the OSCE detailing learning from the Helpful Aspects of Therapy feedback provided by the actor in the role of the patient. The focus of this reflection is on therapeutic dynamics.

Reflective Journal

Your reflective learning log should be presented in this section. The complete reflective learning log should have a beginning (detailing why you want to train as a CBT therapist and your goals), a middle (comprising the three reflective cycles, see below) and an end (a synthesis of the learning that has been accrued at a personal and professional level, and final conclusions). A reflective model should be used to facilitate reflection and this should be evident throughout and appropriately referenced. The reader should be able to see the reflective model in action and see the trainee's learning.

The main body of the reflective log is composed of three 1000-1500 word reflections, completed at regular intervals throughout the year, with each reflection building on the previous one (e.g. putting into action the plan and then reflecting on outcomes). In order to facilitate this, it is useful to keep a diary of events, thoughts and feelings throughout the year, which does not need to be handed in (i.e. this is the data collection stage), and then use a reflective model to analyse the information collected and arrive at overall themes, key learning and action plans (i.e. this is the data analysis stage) for inclusion in the portfolio.

You should use your reflective learning log to help you to identify issues from teaching, clinical work and supervision throughout the year, demonstrating cycles of learning. It is expected that trainees will complete one reflection before the mid-point portfolio submission date, one reflection around September, and the final reflection before the final portfolio submission date in January. Each reflection should include a specific action plan to address the themes identified,

and the following reflection should show how you have acted on this plan, any issues arising from this, and any further actions necessary. The reflective log should work in combination with engagement in the self-practice/self-reflection element of the training year.

Please note that whilst you may wish to further reference this piece of work, there is no requirement to do so, but connection to theory and evidence often deepens the reflective process.

Supervisor and Facilitator Reports

In the final submission of the Practice Portfolio there will be four supervision reports: the interim reports from the service supervisor and the university group supervisor, and the final reports from the service supervisor and the university group supervisor. The sign off form for engagement in SP/SR must also be completed and included in the Practice Portfolio. The templates for these reports are included in this Practice Portfolio. Trainees are expected to inform and remind their supervisors concerning the completion of assessments and submissions.

Trainee Progress Review Form:

Available on PebblePad.

Interim Progress Review

To be completed on PebblePad.

Please note

This review is based on the map of CBT competences for depression and anxiety disorders DH (2007). The review should be completed midway through training, and it is expected that the report will be written by the supervisor, although the HIPI trainee may be asked to provide relevant examples. It is anticipated that thorough comments would be provided which would encapsulate the supervisor's thoughts about the student's competence and professionalism.

The interim review should be completed based on the trainee's stage of training. Therefore, it is acceptable to insert NA (not applicable) where necessary, for the interim report.

	Service Supervisor comments	University Group Supervisor comments
1. Generic therapeutic competences		
Knowledge Awareness of mental health problems, BABCP and ethical guidelines and the CBT model of therapy being employed.		
Building and maintaining therapeutic alliances		

Engagement with client, building and maintaining a trusting therapeutic relationship and effectively disengaging with the client. Rupture-repair skills.		
Assessment skills Ability to make a generic assessment to include an overview of client history, needs, resources and motivation. Ability to produce distress ratings, problem statements and SMART goals. Appraising of risk to client or to others.		
Supervision Able to make use of supervision to maintain and demonstrate reflective practice and is able to accept and utilise constructive criticism. Able to perform effectively in supervision according to the contract agreed.		
2. Basic cognitive and behavioural therapy competences		
Knowledge Sound awareness of basic principles of CBT and BT; awareness of the cognitive biases relevant to common mental health problems, the role of safety behaviours and other aspects of behavioural avoidance for each common mental health problem		
Explaining the rationale for CBT Ability to explain and demonstrate rationale for CBT to client and ability to successfully socialise the patient to the model. Use of psychoeducation appropriately at step 3.		
Structuring sessions Sharing responsibility for session structure and content through: Adhering to an agreed agenda Planning and reviewing practice assignments (homework) Using summaries and feedback to structure the session		
Using measures and self-report records Ability to use IAPT MDS, disorder specific measures and self-monitoring to guide therapy and to monitor outcome		
Developing hypotheses about a maintenance cycle		

Ability to devise cross-sectional maintenance cycle and use this to set targets in the screening and assessment of the client.		
Problem solving Ability to help clients to develop, appraise and implement problem solving to a specific difficulty and/or learn a procedure to be applied to across difficulties		
Ending therapy Ability to plan for the end therapy in an effective and empathic manner and to plan for long-term maintenance of gains after treatment		
3. Specific cognitive and behavioural therapy techniques		
Behavioural techniques Ability to implement exposure to facilitate habituation, planning of behaviours, simple activity monitoring/scheduling and TRAP and TRAC in BA.		
Guided discovery and Socratic questioning Ability to use these skills to facilitate exploration of the client's thoughts, images, beliefs and feelings.		
Specific cognitive techniques Using thought records. Ability to detect, examine and help client reality test automatic thoughts/images. Ability to elicit key cognitions/images. Ability to identify and help client modify assumptions, attitudes and rules. Ability to identify and help client modify core beliefs. Ability to plan and conduct behavioural experiments to test out beliefs.		
Understanding the way the client sees the world, reaching a formulation and developing a treatment plan Ability to develop formulation based on the CBT competency framework and use this to develop treatment plan that matches the published treatment protocol. Ability to produce a formulation that maps and understands client's inner world and response to therapy.		
Understanding and conceptualising co-morbidity using CBT Ability to recognise and appropriately deal with co-morbidity in assessment and then		

phase treatment in order to treat co-morbidity.		
4. Problem specific competencies		
Specific phobias		
Health anxiety		
Social phobia		
Panic disorder (with or without agoraphobia)		
OCD		
GAD		
PTSD		
Depression - using a cognitive therapy approach		
Depression - using a behavioural activation approach		
Metacompetences: generic		
Capacity to:		
1. Use clinical judgement when implementing treatment models		
2. Adapt interventions in response to client feedback		
3. Use and respond to humour displaying sensitivity and interpersonal effectiveness		
CBT specific metacompetences		
Capacity to:		
1. Implement CBT in a manner consonant with the underlying philosophy of the model		
2. Formulate and to apply CBT models to the individual client		
3. Follow the CBT treatment protocol in a client centred manner		
4. Structure sessions and maintain appropriate pacing in CBT sessions		
5. Manage obstacles to CBT including aspects of client resistance.		
Trainee's own comments:		
3 targets identified by the supervisor for ongoing development:		
1.		
2.		
3.		
Service supervisor's signature:		
University group supervisor's signature:		
Supervisee's signature:		
Date:		

Supervisor’s Mid-Year Statement of Achievement

To be completed on PebblePad

CBT competency assessment

		Clinical supervisor’s signature	Date
SUCCESSFUL	The HIPI trainee has demonstrated evidence of achievement of the clinical competencies detailed		
UNSUCCESSFUL	The HIPI trainee has <u>NOT</u> * demonstrated evidence of achievement of the clinical competences detailed.		
<p>* Where this is the case the service clinical supervisor should, after consultation with the Programme Director, include a short report justifying this decision in the space provided below and propose actions that need to be taken by the trainee to remedy the situation.</p>			

Please state the reasons why the trainee has been unsuccessful in achieving the clinical competencies expected of CBT practitioners.

Clinical Supervisor’s signature:

Date:

Group Supervisor’s Mid-Year Statement of Trainee Engagement and Competency

To be completed on PebblePad

Supervision Engagement and Competency Statement

		Group clinical supervisor's signature	Date
SUCCESSFUL	The HIPI trainee has engaged in the process of group supervision in an effective and professional manner throughout and is progressing with learning the necessary CBT competencies.		
UNSUCCESSFUL	The HIPI trainee has <u>NOT</u> * engaged in the process of group supervision in an effective and professional manner throughout and/or is not progressing in learning the necessary CBT competencies as expected.		
<p>* Where this is the case, the group clinical supervisor should include a short report justifying this decision in the space provided below. This will then be considered at an Internal Exam Board. Actions that need to be taken by the trainee and to remedy the situation will be then spelt out. Trainees need to signed off by group supervisors to pass the interim Practice Portfolio submission.</p>			

Please document below the engagement and/or competency issues which mean that the trainee has been unsuccessful using group supervision.

Group Clinical Supervisor's signature:

Date:

SP/SR Mid-Year Engagement Statement Summary

To be completed on PebblePad

SP/SR appraisal

		SP/SR facilitator's signature	Date
SUCCESSFUL	The HIPI trainee has engaged in the process of SP/SR in a mature, effective and professional manner.		
UNSUCCESSFUL	The trainee has <u>NOT</u> * demonstrated sufficient and necessary engagement in the process of SP/SR.		

* Where this is the case, the SP/SR facilitator should include a short report justifying this decision in the space provided below. This will then be considered at an Exam Board. Trainees need to signed-off in terms of SP/SR engagement by the group facilitator to pass the Practice Portfolio.

Please state the reasons why the trainee has been unsuccessful in engaging effectively with SP/SR.

SP/SR facilitator's signature:

Date:

Trainee Progress Review Form:

Final evidence from service supervisor

To be completed on PebblePad

Final Progress Review

To be completed on PebblePad

Please note

This review is based on the map of CBT competences for depression and anxiety disorders DH (2007). The review should be completed at the end of the training year, and it is expected that the report will be written by the supervisor, although the HIPI trainee may be asked to provide relevant examples. It is anticipated that thorough comments would be provided which would encapsulate the supervisor's thoughts about the student's competence and professionalism.

	Service Supervisor comments	University Group Supervisor comments
1. Generic therapeutic competences		
Knowledge Awareness of mental health problems, BABCP and ethical guidelines and the CBT model of therapy being employed.		
Building and maintaining therapeutic alliances Engagement with client, building and maintaining a trusting therapeutic relationship and effectively disengaging with the client. Rupture-repair skills.		
Assessment skills Ability to make a generic assessment to include an overview of client history, needs, resources and motivation. Ability to produce distress ratings, problem statements and SMART goals. Appraising of risk to client or to others.		
Supervision Able to make use of supervision to maintain and demonstrate reflective practice and is able to accept and utilise constructive criticism. Able to perform effectively in supervision according to the contract agreed.		
2. Basic cognitive and behavioural therapy competences		
Knowledge Sound awareness of basic principles of CBT and BT; awareness of the cognitive biases relevant to common mental health problems, the role of safety behaviours and other aspects of behavioural avoidance for each common mental health problem		
Explaining the rationale for CBT		

Ability to explain and demonstrate rationale for CBT to client and ability to successfully socialise the patient to the model. Use of psychoeducation appropriately at step 3.		
Structuring sessions Sharing responsibility for session structure and content through: Adhering to an agreed agenda Planning and reviewing practice assignments (homework) Using summaries and feedback to structure the session		
Using measures and self-report records Ability to use IAPT MDS, disorder specific measures and self-monitoring to guide therapy and to monitor outcome		
Developing hypotheses about a maintenance cycle Ability to devise cross-sectional maintenance cycle and use this to set targets in the screening and assessment of the client.		
Problem solving Ability to help clients to develop, appraise and implement problem solving to a specific difficulty and/or learn a procedure to be applied to across difficulties		
Ending therapy Ability to plan for the end therapy in an effective and empathic manner and to plan for long-term maintenance of gains after treatment		
3. Specific cognitive and behavioural therapy techniques		
Behavioural techniques Ability to implement exposure to facilitate habituation, planning of behaviours, simple activity monitoring/scheduling and TRAP and TRAC in BA.		
Guided discovery and Socratic questioning Ability to use these skills to facilitate exploration of the client's thoughts, images, beliefs and feelings.		
Specific cognitive techniques Using thought records. Ability to detect, examine and help client reality test automatic thoughts/images. Ability to elicit key cognitions/images. Ability to identify and help client modify assumptions, attitudes and rules. Ability to identify and		

help client modify core beliefs. Ability to plan and conduct behavioural experiments to test out beliefs.		
Understanding the way the client sees the world, reaching a formulation and developing a treatment plan Ability to develop formulation based on the CBT competency framework and use this to develop treatment plan that matches the published treatment protocol. Ability to produce a formulation that maps and understands client's inner world and response to therapy.		
Understanding and conceptualising co-morbidity using CBT Ability to recognise and appropriately deal with co-morbidity in assessment and then phase treatment in order to treat co-morbidity.		
4. Problem specific competencies		
Specific phobias		
Health anxiety		
Social phobia		
Panic disorder (with or without agoraphobia)		
OCD		
GAD		
PTSD		
Depression - using a cognitive therapy approach		
Depression - using a behavioural activation approach		
Metacompetences: generic		
Capacity to: 1. Use clinical judgement when implementing treatment models		
2. Adapt interventions in response to client feedback		
3. Use and respond to humour displaying sensitivity and interpersonal effectiveness		
CBT specific metacompetences		
Capacity to: 1. Implement CBT in a manner consonant with the underlying philosophy of the model		
2. Formulate and to apply CBT models to the individual client		
3. Follow the CBT treatment protocol in a client centred manner		
4. Structure sessions and maintain appropriate pacing in CBT sessions		

5. Manage obstacles to CBT including aspects of client resistance.		
Trainee's own comments:		
Service supervisor's signature:		
University group supervisor's signature:		
Supervisee's signature:		
Date:		

Supervisor's Final Statement of Achievement

To be completed on PebblePad

CBT clinical competences

		Practice area clinical supervisor's signature	Date
SUCCESSFUL	The HIPI trainee has demonstrated evidence of achievement of the clinical competencies detailed in this review.		
UNSUCCESSFUL	The HIPI trainee has <u>NOT</u> * demonstrated evidence of achievement of the clinical competences detailed in this review.		
<p>* Where this is the case the service clinical supervisor should, after consultation with the Programme Director, include a short report justifying this decision in the space provided below.</p>			

Please state the reasons why the trainee has been unsuccessful in achieving the clinical competencies expected of CBT practitioners. Practice Area Clinical Supervisor's signature:

Date:

Group Supervisor's Final Statement of Trainee Achievement

To be completed on PebblePad

Group Supervisor Statement

		Group clinical supervisor's signature	Date
SUCCESSFUL	The HIPI trainee has (1) engaged in the process of group supervision in an effective and professional manner throughout and/or (2) displayed the appropriate level of CBT competence.		
UNSUCCESSFUL	The HIPI trainee has <u>NOT</u> * engaged in the process of group supervision in an effective and professional manner throughout and/or displayed the appropriate level of CBT competence.		

* Where this is the case, the group clinical supervisor should use the competency assessment document to document why, in detail, the trainee has not engaged in an appropriate manner or displayed the appropriate competencies. Please provide a short summary below in the space provided. This will then be considered at an Internal Exam Board. Trainees need to be signed off as competent by group supervisors to pass the Practice Portfolio.

Please document below the engagement and/or competency issues which mean that the trainee has been unsuccessful using group supervision.

Group Clinical Supervisor's signature:

Date:

Self-Practice/Self-Reflection Record

To be completed on for trainee use only.

Date:

Preparation notes (e.g. items to take to group)

-
-
-
-

Issue/CBT Method	In-session notes / Reflections	Actions / Plan

Post-session reflections:

SP/SR Engagement Statement Summary

To be completed on PebblePad

SP/SR end of year appraisal

		SP/SR facilitator's signature	Date
SUCCESSFUL	The HIPI trainee has engaged in the process of SP/SR in a mature, effective and professional manner throughout the year.		
UNSUCCESSFUL	The trainee has <u>NOT</u> * demonstrated sufficient and necessary engagement in the process of SP/SR throughout the year.		
<p>* Where this is the case, the SP/SR facilitator should include a short report justifying this decision in the space provided below. This will then be considered at an Exam Board. Trainees need to signed-off in terms of SP/SR engagement by the group facilitator to pass the Practice Portfolio.</p>			

Please state the reasons why the trainee has been unsuccessful in engaging effectively with SP/SR.

SP/SR facilitator's signature:

Date: