Royal Holloway Doctorate in Clinical Psychology

Clinical Competencies

Overview, Map and Specific Competence Standards

Trainees are expected to demonstrate clinical competence with a range of client groups and across a range of clinical settings as outlined in the BPS (2025) accreditation criteria which sets out 9 core areas of competence to be demonstrated by the end of training (see the Core Clinical Competencies section in this document for details). All three courses in the North Thames region (RHUL, UEL, UCL) run a competency-based model of training and as such each trainee will have a varied allocation of placements depending on their competency needs at each placement period. This contrasts to some other DClinPsy programmes where trainees complete core placements in the first two years of training followed by elective placements in the third year. As trainee do not have placements with all client groups, there are several competencies which may be harder to find outside of a particular service, and so at the start of this document we have listed the absolute minimum standards to meet these specific competencies. These do not constitute the whole range of competencies required across training but are provided to give clarity on the minimum work needed in certain areas.

Furthermore, course guidance for the development of specific clinical competencies have been developed in conjunction with members of the Course Clinical Sub-Committee and in consultation with guidance from the CORE frameworks and BPS DCP faculty guidance. Details of basic and advanced competencies have been developed in each of these specific areas: 1. Cognitive Behavioural Therapies 2. Systemic 3. Psychodynamic 4. Psychosis and/or those with distressing unusual experiences 5. Children/Adolescents 6. Older Adults 7. Learning/Intellectual Disabilities 8. Neuropsychology 9. Physical Health Conditions 10. Cultural 11. Leadership 12. Forensic

For the purposes of bringing this together in one place, we have developed this Clinical Competencies document, to provide a map to help trainees, staff, and supervisors to visualise how clinical competencies can be developed over the course of training, together with guidance on the minimum core clinical competencies and specific competence areas.

Responsibility for monitoring the achievement of clinical competence and experience is shared between trainees, supervisors, and the course staff. Several monitoring mechanisms within and across placements are used to determine experience gained and the progress and achievement of clinical competence. These include the ACE clinical log system, the Placement Contract, the MPR Placement Evaluation Form, the EPR Placement Evaluation Form and the trainees' Mid Training Competency Review and Placement Planning forms.

Summary of Essential (minimum) Core Clinical Competencies

Whilst this first section of this document outlines the minimum experience required to meet the essential core clinical competencies, the expectation is that trainees seek out multiple opportunities for gaining competencies e.g., seeking out opportunities to gain experience in working with individuals with intellectual disabilities across both adult and child settings. Many competencies can be met across a variety of placements and as trainees are unlikely to have full placements with all clinical client groups. trainees are encouraged to review the below section of this document with each supervisor prior to starting placement to inform discussions about what experiences it might be possible to gain within the placement. **Please see notes at the end of the section for the process to follow if trainees are aiming to gain competencies outside of the main service of the placement.

PLEASE NOTE: Trainees must complete unique pieces of work to meet each of the following competencies: older adults, acquired cognitive impairment, intellectual disabilities, neuropsychology, psychosis, neurodiversity, and challenging behaviour. Usually, these pieces of work would be with separate individuals, but the content of the work undertaken will be reviewed carefully by the course if more than one piece of work is completed with the same individual. For example, if a trainee conducted a neuropsychological assessment with a working age adult following a stroke, the piece of work could contribute towards their acquired cognitive impairment competencies **or** their neuropsychology competencies. It could not "count" towards both. If, however, the trainee had completed the detailed neuropsychological assessment and formulation with feedback, and then went on to complete an adapted piece of therapeutic work for low mood in the context of post-stroke adjustment, this could then be considered as two pieces of work, one contributing towards neuropsychology competencies and the other contributing towards acquired cognitive impairment competencies (therapeutic intervention). As previously noted, however, we would expect trainees to then seek out further experience with other individuals to contribute further to both these areas of competence. This ensures breadth of experience for trainees across all areas of competence, across multiple pieces of work, with a range of individuals and in various settings and contexts.

Below are outlined the essential (minimum) core clinical competencies.

Please note: where descriptors of competencies indicate a **substantive piece of work** is required to evidence meeting the competency, **substantive work implies more than one contact**; for example, a substantive assessment might include meetings with the individual, their families/carers, their network, multiple forms of assessment, etc.

Working with Older Adults

Trainees MUST have a **minimum of 2 substantive pieces of direct work** with older adults during training. **At least one** of the 2 substantive pieces of direct work **should include intervention**. Working with older adults can include indirect work with families, networks, or staff teams, although trainees **MUST show evidence of direct work with older people** to meet the competency.

Defining Older Adults - The age criteria for access to services for older people varies - in some settings it is 65, in others 70. BPS regulations do not define this group by age (although there is a common misconception it is defined as 65+). In deciding on work which would contribute towards this competency, it is better to think in terms of life-stage rather than age. Ideally, clients would present with issues which support trainees to learn about working with people in later life. Relevant issues in later life might relate to developmental changes and psychosocial adaptation, including role changes and transitions (e.g., retirement), physical health changes, changes in cognitive functioning and progressive impairments or bereavement/loss.

Working both with People with Intellectual/Learning Disabilities and Acquired Cognitive Impairment

Trainees MUST evidence work with individuals across a range of levels of intellectual functioning, **specifically to include experience both with individuals with intellectual disabilities *and* with individuals with acquired cognitive impairment.** Trainees MUST have a **minimum of 2 substantive pieces** of work with these client groups, ideally across the lifespan (i.e., both adult and child), who have significant impairments in their cognitive and adaptive functioning:

- **One** must include work with individuals with **acquired cognitive impairment.** Acquired cognitive impairment might include those who have had a traumatic brain injury, stroke, diagnosis of dementia or Parkinson's disease.
- **One** must include work with an individual with **intellectual disabilities.**
- **At least one** of these 2 substantive pieces of direct work **should include intervention.**

Work with people whose disability makes it difficult for them to communicate

Trainees MUST evidence substantive experience of **adapting therapy and communication** for individuals with impaired communication in the context of the disability, and where appropriate their carers.

Working with People with Psychosis and/or those with distressing unusual experiences

All trainees **MUST have some exposure to work with this client group** during training, **ideally as part of direct therapeutic practice**. This might include people with a diagnosis of psychosis, bipolar disorder, or those experiencing any of the following: hearing voices, seeing visions, experiencing persecutory beliefs, or periods of confusion where they appear out of touch with reality. This should be accompanied by a level of distress and a detrimental change in functioning. This could be in the context of other diagnoses, including delirium, depression, and emotionally unstable personality disorder.

At a minimum, experiences in this area should allow the trainee to gain a sense of the clinical presentation, how services are structured to meet these clients' needs, and how communication may need to be adapted to work effectively and sensitively.

If trainees have not completed a direct therapeutic piece of work with someone with psychosis and/or with distressing unusual experiences, they should gather a range of experiences <u>across</u> training. These could include:

- Shadowing a clinician working with someone with these difficulties
- Joint/individual work with someone with these presenting difficulties
- Attending a ward round
- Group work

Neuropsychology

As a minimum, trainees **MUST have administered, interpretated and fed back the outcome and recommendations of *at least* one neuropsychological or psychometric test** that assesses cognitive, memory, or performance abilities. This can be with an adult or a child. Please note, the assessment measures used should be standardised (that is, they are scored with reference to normative samples). Only using a screening measure such as the Montreal Cognitive Assessment (MoCA), Mini Mental State Examination (MMSE) or the Addenbrooke's Cognitive Examination (ACE-III or ACE-R) would not be sufficient to meet this competency requirement.

For adults, appropriate standardised neuropsychological assessments might include the WAIS-IV, WAIS-V, WMS-IV, DKEFS, RBANS, SIB, NAB, SPANS-X, WASI-II, KBNA, Leiter-3. Similarly, in conducting neuropsychological assessments with children, appropriate standardised neuropsychological assessments might include the WISC-V, WPPSI-IV, WIAT-III, NEPSY-II, Bayley-4, ChAMP, Leiter-3, WNVS, ADOS.

Administration and interpretation of **at least one** test **MUST be observed** by a placement supervisor or other appropriate clinician.

We strongly encourage trainees to gain a broad range of experience: across different test types, presenting difficulties and ages. We therefore encourage trainees to explore opportunities to gain such experiences across all placements. **Neuropsychology competencies include a broad-based understanding of neuropsychological assessment, formulation, *and* intervention techniques, and are more than just administering a test.** Trainees should be able to demonstrate these competencies by, for example:

- Demonstrating knowledge of neuroscience, ageing, brain pathology/injury and neurological recovery.
- Conducting clinical interviews with clients and informants to help guide assessment measure selection and hypothesising.
- Noting behavioural observations and linking these to possible neurological, cognitive, or emotional underpinnings.
- Scoring and interpreting the results of neuropsychological assessments.
- Using the results of the neuropsychological assessment in a formulation, to understand the client's neuropsychological status and facilitate their understanding and adjustment.
- Devising and delivering evidence-based psychological interventions for psychological difficulty in the context of impaired cognitive functioning, which are informed by neuropsychological assessments

Work with people who present with needs associated with neurodiversity

Trainees MUST evidence substantive experience of direct working with individuals who are neurodivergent e.g., autistic individuals. This might include integrating an understanding of neurodiversity in formulation, adapting communication and intervention, or working with the network around the individual. This may be in the context of a formal diagnosis, or a suspected diagnosis.

Work relating to behaviours of distress / behaviours that challenge

This should include use of an evidenced based approach to supporting the individual based on the service context, individual client needs and the behaviours of distress / behaviours that challenge they present with, which might include functional analysis and implementation of positive behaviour support or similar approach.

Work with clients with severe & enduring mental health needs

This might include chronic / recurring / complex presentations such as chronic trauma, depression, anxiety, complex emotional and relational difficulties etc., and the difficulties having an impact on several areas of functioning.

Work with clients in an inpatient setting (health / forensic / paediatric / psychiatric / residential service)

All trainees should have some exposure to working in an inpatient setting during training. At a minimum, this contact should enable trainees to gain a sense of the environment (practicalities, roles of different professions, role of clinical psychology within the setting etc.). We strongly encourage trainees to seek out and gain a broad range of experience: across settings, client group, direct/indirect work, etc.

Work with carers, families, and wider systems

All trainees must have experience of working with carers, families, and wider systems, preferably across more than one placement context. This may be direct work e.g., delivering a family intervention, or indirectly e.g., working with other professionals to support someone in their role as carer.

Cognitive Behaviour Therapy + One Other Model of Therapy

Trainees must have substantive experience of Cognitive Behaviour Therapy and at least one other model of therapy. **Please note:** third wave approaches (e.g., ACT, DBT, CFT, MBCT, MBSR, Mindfulness etc.) are not considered as another model, these would fall under CBT competencies.

Digital practice

Trainees must have experience of digital practice on a minimum of **at least one placement** whilst on training, but would usually need to gain experience across multiple placements to allow them to:

- Develop both knowledge about and limitations of digital practice.
- Develop ability to effectively provide services (including teaching, supervision, assessment, formulation, consultation and intervention with individuals, families, groups, and multi-disciplinary teams and evaluation of outcomes and experiences, including service evaluation). This could include for example offering psychological interventions by telephone and videocall and using apps.
- Develop knowledge of the ethical dimensions which arise from the use of digital technologies, as well as awareness of their own attitudes, skills and values regarding digital practice and the capacity to reflect on these.

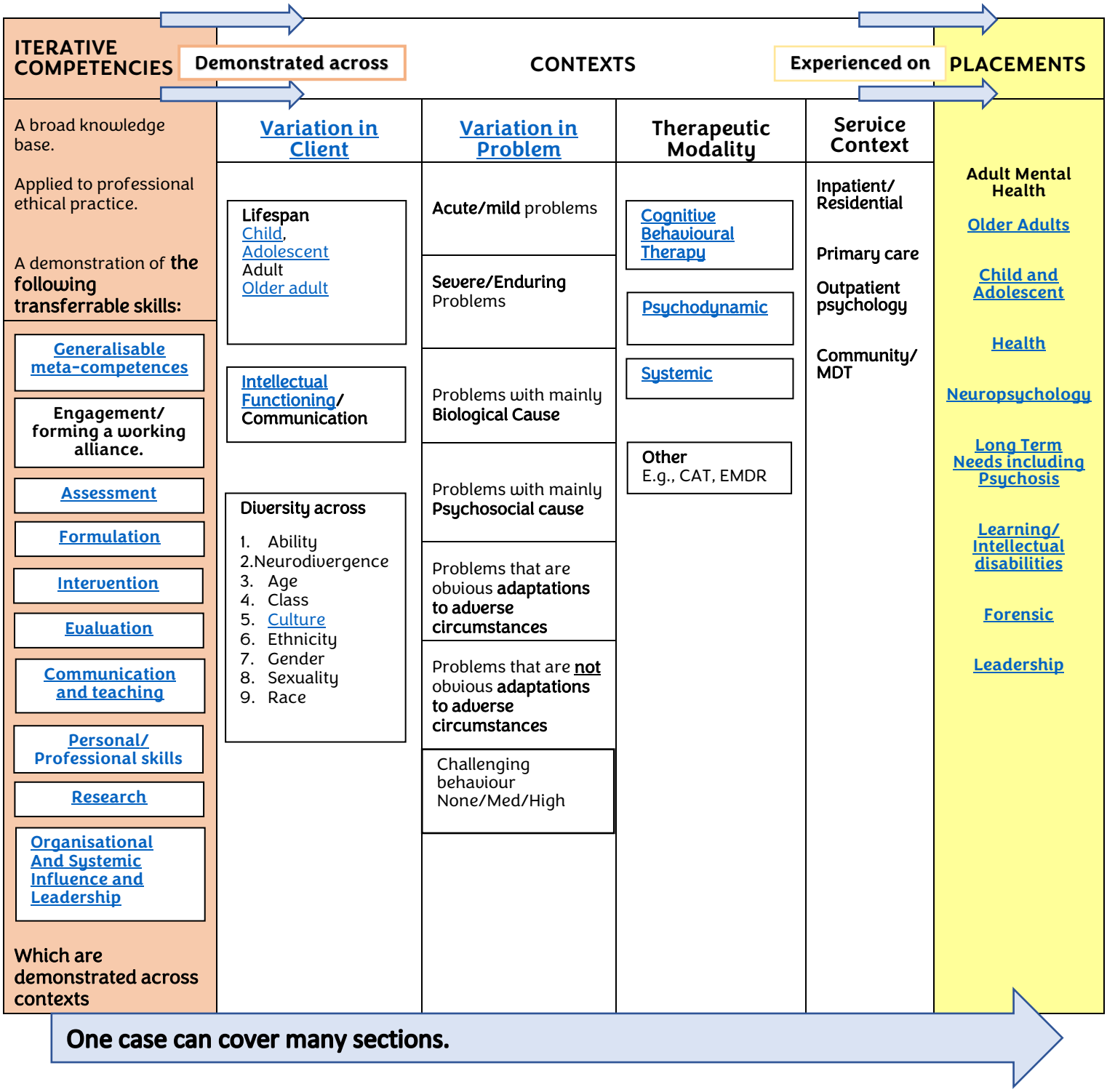
Gaining competencies in neighbouring services / teams

**As noted at the start of this document, trainees will not have placements with all client groups. To support trainees in meeting the above minimum core essential competency requirements trainees may pick up discrete pieces of work within neighbouring services whilst on a placement. We therefore encourage trainees and supervisors to, where possible, seek out these opportunities on all placements, to support trainees gaining a breadth of experience across training. For example, a trainee on a yearlong IAPT placement in the first year may deliver a group intervention in a local inpatient acute mental health service with a clinical psychologist based in that service. This would add breadth to their adult mental health experience and support them in gaining experience to contribute towards their inpatient competencies.

Important points to remember when exploring gaining competencies in neighbouring services / teams:

- Firstly, trainees must always first discuss in detail with their named placement supervisor the opportunities available on the placement itself, referring to this competency document. Focusing on the main placement is the priority and so exploring what is possible within it directly would be the first port of call.
- If there are some areas of competence not directly available on the placement, trainees and supervisors can consider if there are any linked / neighbouring services where experience can be gained to meet any competencies not offered by the placement.
    - If there are and the supervisor agrees it would be possible for the trainee to do work in another service alongside meeting the competencies of their placement it should be discussed how best to arrange these opportunities e.g., would the supervisor liaise with the other service in the first instance or should the trainee take the lead, etc.
    - Liaison with the other service should explore what opportunities are possible (it would help to consult this document to share what sorts of experience would help to contribute to meeting competencies)
    - The trainee to agree with the main placement supervisor and the supervisor in the linked / neighbouring service:
        - what work will be undertaken,
        - how many days / frequency of time on the neighbouring service
        - what supervision will be required to support the work and who will offer this
        - what input the supervisor in the neighbouring service will have to the MPR and EPR paperwork and meetings to reflect the work undertaken and competencies developed in the service
    - The plan agreed should be noted in the MPR/EPR paperwork to keep the course informed.
    - If supervisor or trainee would like support or advice around this process, they should contact the trainee's course directly, who would be happy to discuss further.
    - **An example:** A trainee is on placement in a tier 2 CAMHS service. There is a linked CAMHS-Disability service. It is agreed the trainee will undertake a piece of PBS work with a family. They agree that a clinical psychologist in the CAMHS-Disability service will offer weekly 30 mins supervision across the piece of work, with the trainee using ½ a day a week to do the work across 6 weeks of the placement. This would contribute to the trainee's competencies in working with challenging behaviour and working with families / carers / wider systems. The supervisor in the CAMHS-Disability placement provided verbal feedback to the main placement supervisor about the trainee's work with them and added summary comments to the MPR-EPR paperwork regarding this piece of work, but they did not attend the MPR or EPR meetings.

Clinical Competencies Map



Variation in Clients and Problems: Brief Overview

A fundamental principle is that trainees work with clients across the lifespan, such that they see a range of service users whose difficulties are representative of problems across all stages of development. These include:

- problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions;
- service users with significant levels of behaviours that challenge;
- service users who experience mental health difficulties;
- service users across a range of levels of intellectual functioning over a range of ages, specifically to include experience with individuals with intellectual disability and acquired cognitive impairment;
- service users who present with issues associated with neurodiversity;
- service users whose disability makes it difficult for them to communicate;
- service users may also include carers and their families members;
- service users need to be from a range of backgrounds reflecting the demographic characteristics of the population.

Specific Competence Standards

The following specific competence standards have been developed in line with good practice guidance from relevant professional bodies (e.g. BPS, BABCP, AFSP etc) and demonstrate what trainees would expect to gain on a placement within this specific area of clinical psychology.

In addition to the minimum core competencies outlined at the start of this document, these specific standards are available to give trainees and supervisors additional information about what competences would be expected for a specific placement setting (e.g. in Older Adults or Learning/Intellectual Disabilities) or what competencies trainees should expect to gain across multiple settings over the course of training (e.g. Cultural, Leadership). There are additionally guidelines provided for trainees on Forensic placements, although it is not expected that all trainees will have a placement in a specific Forensic setting.

The following specific competence standards follow, split into 'basic' (usually expected all trainees will gain over course of training) and 'advanced' (usually expected trainees would aim towards gaining if on a specific placement in this setting):

1. Cognitive Behavioural Therapies
2. Systemic
3. Psychodynamic
4. Psychosis and/or those with distressing unusual experiences
5. Children/Adolescents
6. Older Adults
7. Learning/Intellectual Disabilities
8. Neuropsychology
9. Physical Health Conditions
10. Cultural
11. Leadership
12. Forensic (only relevant to trainees on specific forensic placements)

Therapeutic Modalities

Trainees must have substantive experience of Cognitive Behaviour Therapy and at least one other model of therapy. Below competencies are outlined for CBT, and Systemic and Psychodynamic, as main therapeutic modalities trainees most commonly develop core competencies in during training.

Cognitive and/or Behavioural Therapies Competences

All trainees must develop competencies in CBT during training. Trainees should be able to demonstrate a broad-based understanding of the theoretical basis of CBT and its application across a range of problem areas. These will include, but not be limited, to:

BASIC/ESSENTIAL

In order to demonstrate the following competencies trainees are required to undertake at least eight pieces of direct clinical work.

Knowledge of the basic principles of CBT.
An ability to demonstrate and provide a rationale for CBT to the client including their active role, the collaborative nature of therapy, and the use of homework.
An ability to structure sessions including adhering to an agreed agenda, planning and reviewing practice assignments, and using summaries and feedback.
An ability to use guided discovery and Socratic questioning.
A clear understanding of the cognitive and behavioural maintaining factors to guide assessment and treatment including common cognitive biases relevant to CBT and the role of safety-seeking behaviours.
An ability to collaboratively develop a theory-based formulation that specifically relates to the client, is well integrated, and can be used to identify agreed targets/goals for the intervention and consider potential obstacles.
An ability to promote therapeutic change through the use of: activity monitoring and scheduling; problem-solving; thought records; exposure techniques; planning and conducting behavioural experiments; relaxation and applied tension; modifying safety seeking behaviour (including avoidance and escape); reappraising automatic thoughts, assumptions and images; and identifying and modifying core beliefs.
An ability to apply cognitive behavioural principles to the treatment of a range of presentations, usually including anxiety disorders (e.g. social phobia, panic disorder, OCD, GAD, PTSD) and high and/or low intensity interventions for depression.

ADVANCED/DESIRABLE

An ability to adapt cognitive behavioural principles to different client groups including children, older adults, people with long-term health conditions, cognitive impairments and longer-term needs.
A capacity to use clinical judgement when implementing therapy and to adapt interventions in response to the client.
An ability to consult other professionals and teams on CBT understanding of people's difficulties.

NB. Those on the BABCP pathway will be required to have conducted a minimum of 200 hours of supervised assessment and therapy during training.

These criteria are based on the Basic CBT Competences, the Specific Behavioural Competence and the Problem Specific Competence Frameworks, the BPS Standards of Education and the BABCP accreditation criteria of CBT therapist.

Systemic Competences

Trainees should be able to demonstrate a broad-based understanding of the theoretical basis of systemic therapies and their application with individuals, families and organisations across a range of developmental stages. These will include, but not be limited, to:

BASIC/ESSENTIAL

The below outlines what trainees should demonstrate if Systemic is their second therapeutic model.

Demonstrated knowledge of systemic principles, theories and approaches that enable therapeutic change.
An ability to hold a relational, contextual, reflexive and non-pathologising view of the system and use language in a way that reflects this.
An ability to develop systemic formulations and hypotheses which are shared and adapted collaboratively with clients.
An ability to develop and maintain engagement with multiple members of the system.
An ability to help clients identify and work towards appropriate relational goals.
An ability to work with individual and family strengths.
An ability to map systems using genograms, ecomaps and timelines.
An ability to use specific systemic techniques, e.g. circular interviewing and questions, externalising, enactments.
An ability to manage endings with multiple members of the system.
Have experience of working within a systemic team, e.g. a reflecting team, open dialogue service.
Recognise the influence of wider social contexts on self and clients, and how inequalities and power differentials impact on people's lives and systemic practices
Take a self-reflexive approach which considers their own personal family and cultural experiences from a systemic perspective, and how these influence professional practice

ADVANCED/DESIRABLE

It is likely that the following additional competences would be developed through a specific Systemic placement.

An ability to undertake a systemic assessment to inform a relational, circular and contextual understanding of the problems from multiple perspectives.
An ability to use systemic ideas to understand organisational change.
An ability to establish the context for a systemic intervention, e.g. setting up a network meeting.
An ability to use systemic outcome monitoring to promote change.
An ability to facilitate systemic consultations which help other professionals to take a systemic understanding of their clients.
An ability to use systemic ideas to address difficulties in couple relationships.

These criteria are based on the Basic Systemic Competences, the Specific Systemic techniques and the Problem-Specific Competence Frameworks, the BPS Standards of Education, and AFSP Training Standards and Accreditation.

Psychodynamic Competences

Throughout the course of the training, trainees should be able to demonstrate a broad-based understanding of the theoretical basis of psychodynamic approaches to therapy and their application across a range of problem areas. These will include, but not be limited to:

BASIC/ESSENTIAL

The below outlines what trainees should demonstrate if Psychodynamic is their second therapeutic model.

An ability to make use of the therapeutic relationship as a vehicle for change.
Knowledge of the basic principles of, and rationale for, analytic/dynamic approaches, including core principles of developmental theory, attachment theory and the psychodynamic model of the mind, as well as an understanding of the role of transference and counter-transference in relationships.
An ability to assess the likely suitability of an analytic/dynamic approach for particular clients.
Ability to formulate using a psychodynamic model, linking past and present relationships and conflicts.
An ability to maintain an awareness of environmental factors in the formulation, such as racism, and not being limited to intrapsychic factors.
An ability to maintain an analytic approach, to derive an analytic/dynamic formulation and to engage the client in analytic/dynamic therapy.
An ability to maintain an analytic/dynamic focus, to identify and respond to difficulties in the therapeutic relationship, and to work with the client's internal and external reality.
An ability to establish and maintain the therapeutic frame and helpful therapeutic boundaries, and an understanding of unconscious meanings for clients when deviations/changes occur (e.g. a room change). Ability to reflect on these.
An ability to apply the psychodynamic model in response to the client's individual needs and context.
Ability to provide attunement to a client's needs and experiences and to provide containment in the therapeutic relationship.
An ability to take a critical, self-reflective stance in supervision and reflective practice groups.

ADVANCED/DESIRABLE

It is likely that the following competences would be developed through a psychodynamic placement.

An ability to make dynamic interpretations.
An ability to work with transference and counter-transference.
An ability to identify and work with defences.
An ability to work through the termination phase of therapy in a planned manner.
An ability to adapt psychodynamic therapy for work with children and young people.
An ability to work with unconscious communication (e.g. dreams, narratives, free associations, and with children, play) including facilitating exploration of unconscious dynamics influencing relationships and helping clients become aware of unexpressed or unconscious feelings.
An ability to adapt psychodynamic therapy for the treatment of borderline personality disorder including mentalisation based treatments, transference focused treatments and interpersonal group psychotherapy.
Knowledge of, and an ability to deliver, problem-specific psychodynamic therapy, which may include panic focused, interpersonal therapy, supportive-expressive, and time-limited, interpretive group therapy for pathological bereavement.
An ability to identify and skilfully apply the most appropriate analytic/dynamic technique.
An ability to establish an appropriate balance between interpretive and supportive work.
An ability to bring oneself into supervision- one's own responses, biases, values and being able to reflect on these. An ability to reflect on power dynamics within the therapeutic relationship and within supervision.

These criteria are based on the Basic Analytic/Dynamic, the Specific Analytic/Dynamic Techniques, and the Problem Specific and Specific Metacompetencies Frameworks.

Other Specific Competence Areas

Competences for Working with People with Psychosis and/or Distressing Unusual Experiences

All trainees must have some exposure to work with this client-group during training (see above essential competencies section), ideally as part of direct therapeutic practice. Trainees should aim to develop a portfolio of different experiences in this area across training, which should enable them to demonstrate an awareness of the symptoms of psychosis, the difficulties faced by people experiencing psychosis, and the types of service and intervention which may help people experiencing psychosis. Competencies can be developed in this area through clinical work with a range of presentations: people with psychotic diagnoses broadly-construed (e.g. Schizophrenia, First Episode Psychosis, Psychotic Depression, Bipolar Affect Disorder), psychotic symptoms in isolation (e.g. hallucination and delusion), psychotic symptoms within the context of other mental health conditions (e.g. voice-hearing or paranoia in Emotionally Unstable Personality disorder), or work with other conditions which involve loss of contact with reality, such as delirium or dissociative disorders. Where trainees have a placement focused on working people with psychosis, it is expected that they would gain the following competencies:

BASIC/ESSENTIAL

Knowledge of presenting issues, diagnostic criteria, basic knowledge of psychopharmacology and common physical health problems among people with psychosis or bipolar disorder.
Knowledge of, and ability to operate within, ethical, professional and legal guidelines relating to working with people with psychosis, bipolar disorder and/or other distressing unusual experiences.
Awareness of the values, knowledge and skills involved in promoting equality of opportunity and respect for cultural diversity among people with psychosis, bipolar disorder and other distressing unusual experiences, and their families, and challenging inequalities and discrimination.
Ability to develop a good therapeutic alliance and carry out a psychological assessment including risk management, and assessment of the person's functioning in multiple systems, with a client with psychosis, bipolar disorder and/or other distressing unusual experiences.
Ability to develop a shared formulation, with reference to theoretical models of psychosis/bipolar disorder and empirical evidence, and to co-ordinate casework or plan an intervention across different agencies/individuals.
Demonstrate an understanding of confidentiality, capacity and consent issues in relation to working with individuals with these experiences.
An ability to use appropriate outcome measures for use with clients with these experiences.
An ability to carry out indirect work engaging and working with families/carers/staff/wider professional network of individuals involved.
Experience/exposure to organisational contexts in which clinical psychologists work with people with psychosis and/or bipolar disorder, and to develop a practical understanding of the role of clinical psychology in working with this population.

DESIRABLE

To work with a number of clients with psychosis and/or bipolar disorder.
To conduct a variety of psychological assessments (including assessments of psychological well-being, psychometric assessments and assessments of adaptive functioning) demonstrating ability to adapt these to a range of cognitive, communication, sensory, social and physical needs of individuals with learning (intellectual) disabilities.

To be familiar with and gain experience of delivering a range of interventions for people with psychosis or bipolar disorder including, for example, CBT, family interventions, interpersonal psychotherapy, psychoeducation and relapse prevention, and management of co-existing issues (e.g. depression/anxiety, substance misuse, LD).
To carry out at least one observed clinical practice (in vivo or via recording) with rating of formal competence assessment tool with a client with psychosis or bipolar disorder.
An ability to develop and deliver group-based interventions for people with psychosis or bipolar disorder and their families/carers.
Ability to draw on a range of meta-competencies relevant to working with people with psychosis or bipolar disorder.
To gain experience of/exposure to wider systems and contexts which people with psychosis or bipolar disorder may be part, including a variety of health, housing and social care services, supported living and residential care, inpatient settings, forensic settings and those within the third sector/service user and carer involvement.
To contribute to research/service evaluation/service development within a secondary mental health context.
To seek opportunities within supervision to reflect upon and manage the effects of differences between themselves and the clients they are working with, and the personal impact of this work.

These criteria are based on the UCL Competence framework for psychological interventions with people with psychosis and bipolar disorder.

Child and Adolescent Competences

All trainees must work with children/adolescents during training. Trainees should have a broad-based understanding of the theoretical basis and clinical skills for work with children and adolescents and their wider systems. These will include, but not be limited, to:

BASIC/ESSENTIAL

To demonstrate the competences below trainees are expected to undertake at least 8 pieces of clinical work.

Knowledge of child and adolescent development, attachment, developmental milestones, mental health problems in children/young people, impact of wider systems and parenting practices on development, and family development and transitions.
Knowledge of, and ability to work within, legal frameworks, professional and ethical guidelines (e.g. child protection policies), and issues of confidentiality, informed consent, and capacity/competence relevant to working with children/young people.
An awareness of risk and child protection issues, and an ability to gather information to make a risk assessment, appropriate decisions regarding risk, and risk management.
An ability to engage with children and young people of different developmental stages, ages and backgrounds using age-appropriate language, play and other media (e.g. artwork), and an ability to engage and collaboratively work with families, parents and carers.
An ability to undertake a comprehensive assessment, including information from the wider system, and to develop a formulation which includes an understanding of the child's difficulties and functioning in the context of family, school, community, culture, and social network.
An ability to develop and implement a psychological intervention in collaboration with parents, carers and children and to set goals that are achievable, realistic, and responsive to context.
An ability to systematically evaluate interventions with children, parents/carers, and to modify the formulation/intervention in response to feedback.

ADVANCED/DESIRABLE

An ability to undertake a range of specialist assessments for children/young people including mental state, psychometric, diagnostic assessments, structured behavioural observations, and/or structured cognitive, functional and developmental assessments, where relevant to the placement context
An ability to work within and across different agencies (e.g. schools, police, social care).
Knowledge of, and an ability to carry out, specific interventions designed for use with families and/or children/young people (e.g. problem-solving, social skills training, functional family therapy, multi-systemic therapy, systemic therapy and adapted CBT therapy, positive parenting programmes, and interventions for challenging behaviour).
An ability to deliver prevention programmes designed for use with families and or children/young people including self-help, health promotion and emotional health promotion in schools or similar settings.
An ability to plan, execute and evaluate clinical research, which addresses childhood and adolescent difficulties, and show an understanding of the specific ethical issues in research with children and young people.

These criteria are based on the Competences Framework for Children and Adolescents with Mental Health Problems and the BPS/DCP Faculty for Children and Young People (2006). Good Practice Guidelines for UK Clinical Psychology Training Providers.

Work with Older Adults Competences

All trainees must work with older people during training. Trainees should be able to demonstrate a broad-based understanding of the theoretical basis and clinical skills for work with older adults. These will include, but not be limited, to:

BASIC/ESSENTIAL

Undertake at least two pieces of clinical work to include development of skills in the following:

Assessment, formulation and intervention with clients aged 65+, presenting with mental health or functional difficulties related to issues/events typical of later life (e.g. bereavement, changing physical health, retirement/life role transitions etc).
Assessment and intervention with at least one client presenting with a cognitive (sometimes termed "organic" in services) problem related to issues typically experienced in later life (e.g. dementia, stroke).
At least one of the 2 substantive pieces of direct work should include intervention.
Indirect working with families/carers/staff/wider professional network of older adults.
Working across a range of settings, including with clients being seen at home, or those in a long term care setting, such as a nursing or residential home, ward or day hospital.
Knowledge of the organisational contexts in which clinical psychologists work with older people, to develop a practical understanding of the role of clinical psychology in working with this population.

ADVANCED/DESIRABLE

It is likely that the following competences would be developed through a placement with a mental health or other health service specifically for older adults:

Working with a number of adults presenting with issues related to later life (including a wide variety of functional/mental health problems, and cognitive/"organic" presentations) across the age range, including the "younger old" (65+) and "older-old" (85+).
Assessment and interventions with older adults with complex problems (e.g. co-existing presenting difficulties such as stroke, dementia, depression, a late life stressful event, poor physical health, substance abuse or drug dependency etc).
Conducting a variety of psychological assessments, demonstrating ability to adapt these to a range of cognitive, communication, sensory, social, and/or physicalhealth needs of older people.
Developing multi-faceted formulations and interventions with older people and their systems which take into account individual, systemic and organisational factors.
Experience of interventions especially developed for older adults and/or their carers.
Experience of/exposure to wider systems and contexts of which older people may be a part, including a variety of health and social care services, and the voluntary sector.
Developing an ability to reflect upon and manage the effects of differences in age between self and older older clients, and the personal impact of working with older adults.

These criteria are based on the BPS DCP PSIGE (2006). Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People. BPS: Leicester

Competences for working with people with Intellectual (Learning) Disabilities

All trainees must work with people with intellectual (learning) disabilities during training. Trainees should be able to demonstrate a broad-based understanding of the theoretical basis and clinical skills for work with people with intellectual (learning) disabilities. These will include, but not be limited, to:

BASIC/ESSENTIAL

Undertake psychological assessment and intervention work with a client whose behaviour is constructed as 'challenging' to services, to typically include a comprehensive functional analysis assessment leading to development of positive behaviour support guidelines.
Undertake at least one direct assessment and therapeutic intervention with a client with intellectual disabilities where adaptations are needed to ensure work is accessible to the client.
An ability to work with individuals whose disability makes communication difficult.
To work with at least one individual with neurodivergence such as autism.
Knowledge of capacity and consent issues where intellectual functioning is impaired, and an ability to obtain informed consent.
An ability to carry out indirect work with families/carers/staff/professional network.
Knowledge of the organisational contexts in which clinical psychologists work with people with intellectual disabilities, to develop a practical understanding of the role of clinical psychology in working with this population.

ADVANCED/DESIRABLE

It is likely that the following competences would be developed through a placement in a specific service for children and/or adults with intellectual (learning) disabilities.

To work with a number of clients with intellectual disabilities across the lifespan, including young children, school age children, adolescents and those in transition from child to adult services, adults and older adults with intellectual disabilities (relative to the placement setting e.g. child or adult).
Undertake psychometric assessment with a client with intellectual disabilities.
An ability to work across a range of impairments, to include experience of/exposure to the role of clinical psychology for individuals with severe/profound intellectual disability.
To work with clients with a range of communication needs, including non-verbal clients.
To conduct a variety of psychological assessments (including assessments of psychological well-being, psychometric assessments and assessments of adaptive functioning) demonstrating ability to adapt these to a range of cognitive, communication, sensory, social and physical needs of individuals with intellectual disabilities.
An ability to develop multi-faceted formulations and interventions which take into account individual, systemic and organisational factors.
Completion of/involvement in a Mental Capacity Act (2005) assessment.
Knowledge of the wider systems/contexts which people with intellectual disabilities may be part.
Ability to reflect upon and manage the effects of disability/differences between themselves and the clients they are working with, and the personal impact of this work.

Adapted from the BPS DCP Faculty for People with Learning Disabilities (2012). Good Practice Guidance for UK Clinical Psychology Training Providers for the training and consolidation of clinical practice in relation to adults with learning disabilities.

Neuropsychological Competences

To demonstrate minimum neuropsychological competencies, trainees must have administered, interpreted and fed back the outcome and recommendations of *at least* one neuropsychological or psychometric test that assesses cognitive, memory, or performance abilities. This can be with an adult or a child.

More generally, trainees should demonstrate a broad-based understanding of neuropsychological assessment, formulation and intervention techniques. These will include, but are not limited to:

BASIC/ESSENTIAL

Knowledge of neuroscience, normal ageing, brain pathology/injury and neurological recovery; methods and conceptual approaches used in clinical neuropsychology; advances in neuroscience research/practice and implications for neuropsychological theory/practice; contemporary models of health, disability and participation; and common neuropsychological, neurological and neuropsychiatric conditions.
An ability to identify cognitive impairments, behavioural changes and emotional difficulties and provide an integrated psychological/neuropsychological approach to manage these.
An ability to use behavioural observations and to map these to possible neurological, cognitive or emotional underpinnings.
An ability to administer and interpret the results of a range of neuropsychological assessments (see introductory information in this document for suggested suitable assessment measures)
A clear understanding and ability to discuss the implications of neuropsychological assessment results, for example how these might be used to determine access to services and support.
A clear understanding of the basic statistical principles on which neuropsychological assessments are founded and the need for standardised presentation of assessment materials.
An ability to give appropriate feedback on neuropsychological assessment results to clients/carers, including the formulation and appropriate recommendations.
An ability to adapt style of communication to people with neuropsychological disorders.
An ability to construct a formulation to understand the client's neuropsychological status, facilitate their understanding and adjustment, and where possible to devise and deliver evidence-based psychological/neuropsychological interventions, which are adapted for psychological difficulty in the context of impaired cognitive functioning.

ADVANCED/DESIRABLE

An ability to demonstrate familiarity with a range of neuropsychological assessment materials, and to be able to select, administer and interpret a tailored neuropsychological assessment.
An applied understanding of the management and rehabilitation of neuropsychological and/or neurological disorders.
Knowledge of the political and organisational context of neurorehabilitation services, as well as NHS and Social Services procedures, including arrangements for community care, support for neurological disability, and care for people who lack capacity.
Knowledge of formal documents in relation to ethical practice, legal and statutory obligations and professional standards as applied clinical neuropsychology.

Above is from The BPS Standards for the accreditation of programmes in adult neuropsychology.

Physical Health Conditions Competences

All trainees must work with people presenting with persistent physical health conditions during training. Throughout the course of the training, trainees should be able to demonstrate a broad-based understanding of the theoretical basis and clinical skills for work with people with persistent physical health conditions. These will include, but not be limited, to:

BASIC/ESSENTIAL

Work with at least two clients and to include development of skills in the following areas:

Knowledge of presenting issues and diagnostic criteria in physical health conditions, the impact of physical health conditions in the context of a person's life stage, models of behaviour change, a generic model of medically unexplained symptoms and generic models of adjustment to physical health conditions.
An ability to apply psychological principles in different service contexts including medical settings and primary care.
An ability to undertake a comprehensive biopsychosocial assessment including assessment of social, biological, psychological, and cultural factors, issues of risk, and the person's functioning within multiple systems. As part of this, trainees should incorporate understanding of how the experience of historic and current structural, institutional, and interpersonal racism and other forms of discrimination may impact on a person's health and disparities that may experience in relation to their health.
An ability to develop a collaborative formulation which explains the development and maintenance of the client's difficulties in relation to their physical health condition, and to plan an intervention based on the formulation.
An ability to promote the client's capacity for adjustment including reflection on adverse impact and adaptation to illness, identifying aims/personal resources for adjustment and adopting strategies to facilitate adaptation.
An ability to promote behavioural change through engaging the client in a collaborative process, setting goals and identifying target behaviours, developing action plans, using behavioural experiments, encouraging habituation of new behaviours, and monitoring, reviewing and maintaining change related to health condition.
An ability to apply psychological principles to support clients' capacity for self-management of their physical health problem.
An ability to contribute to multidisciplinary meetings and treatment plans, and working with the MDT to integrate psychological thinking/approaches and develop the service.

ADVANCED

An ability to deliver group-based interventions for people with physical health conditions.
An ability to develop and implement self-help/self-management programmes.
Knowledge of and an ability to assess mental capacity and decision-making.
An ability to deliver difficult or unwelcome communications in a sensitive and effective way e.g., in the context of supporting a person and their family in the engagement of treatment.
Knowledge of and an ability to operate within the professional, ethical and legal guidelines relevant to working with people with physical health conditions.
An ability to operate within and across organisations relevant to those with a physical health problem, including communicating with different agencies, knowledge of interagency policies and procedures and their roles and responsibilities.
An ability to deliver specific interventions to clients presenting with a range of physical health problems (e.g. diabetes, chronic fatigue, chronic pain, IBS, non-dissociative seizure, neurological presentations).

These criteria are based on the Core Knowledge and Clinical Competences Framework for Psychological Interventions with People with Physical Health Conditions.

Cultural Competence & Cultural Humility

All trainees must demonstrate the below cultural competence (developing knowledge), aiming to develop ongoing cultural humility (ongoing self-awareness, self-reflexivity and learning) during training. Although this is positioned within 'cultural' competence and humility, it is expected that this reflects understanding and competence in relation to a wide range of diversity reflecting broad social GGRRAAACCEEESSS.

Knowledge of key evidence and an understanding of the importance of paying careful attention to issues of difference and diversity in relation to theory, clinical work and research/evidence base.
The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives.
Knowledge of different cultures and awareness of the potential significance for practice of social and cultural difference, across a range of domains, including but not limited to: ethnicity, culture, class, religion, gender, age, disability and sexual orientation.
Being sensitive to own personal values, beliefs and biases and how these may influence perceptions of the client, the client's problem, and the therapeutic relationship.
Being culturally aware and sensitive to own cultural heritage and to valuing and respecting differences.
Being aware of differences which exist between oneself and one's clients in terms of race, gender, sexual orientation, disability and other socio-demographic characteristics.
An understanding of the impact of power imbalances, prejudices and oppression on the experiences of those from minority backgrounds.
An understanding of the intersection of oppression due to marginalised experiences and how this shapes an individual's unique lived experience of prejudice.
An understanding of the world view of culturally diverse clients and how this may shape expectations for the therapeutic relationship and acceptability and/or effectiveness of intervention.
An understanding about potential barriers that may impact on the accessibility and perceived usefulness of mental health services for diverse clients.
To have knowledge of professional guidance and policies relevant to working with difference and diversity.
An ability to conduct assessments, develop formulations and carry out interventions in a manner that is not prejudiced.
Where social and cultural difference impacts on accessibility of interventions, an ability to make appropriate adjustments to the therapy, with the aim of maximising its potential benefit to the client.
Ability to follow best practice when working with interpreters, to identify potential difficulties, and to review the work undertaken.
Ability to develop formulations which incorporate the person's cultural and social identity and values, and understanding of the way in which the intersections of the client's, supervisor's and trainee's cultural and social values shape the development of the formulation.
An ability to reflect on the ways in which one's own and client's contexts may influence what goes on in clinical practice and the wider service and professional context, and vice versa.
An ability to consider issues of difference (including but not limited to race, culture, religion, gender, sexuality, disability, age) as a routine part of discussion in supervision.
A willingness to take an anti-racist and anti-discriminatory stance in professional and client relationships and at an organisational level.

Leadership Competences

All trainees must develop leadership competencies during training. Throughout the course of the training, trainees should develop knowledge and skills on placement which contributes to their development as effective leaders. These will include, but not be limited, to:

BASIC/ESSENTIAL

All trainees are expected to gain the following leadership competences over the course of training:

Formulation skills from more than one psychological model to inform interventions, and an ability to take the lead in presenting formulations to clients, colleagues and teams.
Awareness, building, and maintenance of interpersonal relationships.
An understanding of the emotional impact of change (including resistance).
An ability to be self-reflective and to help others to self-reflect.
An ability to lead on complex psychometric assessment and to undertake a comprehensive psychological assessment including risk.
Across at least two placements, to demonstrate ability to identify opportunities for involvement of/collaboration with/co-construction with service users and carers, outside of the therapeutic relationship, and to take a lead on developing/implementing such co-construction activities within teams/services.
Take a lead on a service-related research project that explicitly includes feedback to the service on any recommendations/ implications.
Identify any opportunities for supervision, mentoring, consultation, teaching and training others that are appropriate to the trainee role.
Gain experience of actively identifying training needs and discussing these with supervisor, using this discussion to help prioritise the agenda for supervision.
Take a lead on supervision or consultation to a professional from a discipline other than psychology on a single case.
Gain experience of self-managing workload to fulfil course and clinical (placement) requirements.
Seek out opportunities to present at team/trust away days/meetings.

ADVANCED/DESIRABLE

It is expected the below competences are likely to be met on a specialist / leadership-specific placement:

Take a lead on psychological care-planning for a client.
Skills in coordinating research teams (supervisors, governance officers and collaborators).
Use discussion of strategy to develop and maintain effective working relationships with other team members.
Ability to use evidence (e.g. from the literature/guidelines), data collection, outcomes and audit to constructively critique current service practice.
Identify and discuss issues in supervision that relate to leadership (e.g. team dynamics/ team management and the role of psychologists in their management) with a specific focus on the strategies that a clinical leader needs to adopt.
Assist with “public relations” and “marketing” activities (e.g. presentations to interested parties about training).
Develop reflective practice in relation to self-evaluation of progress in training (both development and training needs) on the basis of systematic monitoring of the impact of interventions.

Forensic Competences

It is not expected that all trainees will complete a Forensic placement. Where trainees do undertake a forensic placement, the below outline expected clinical competences. It should be noted that these only apply to trainees who have undertaken a forensic placement; trainees who do not complete a forensic placement are not expected to develop specific forensic competencies beyond skills required in general clinical practice, e.g. the assessment of risk to others.

ESSENTIAL

An ability to generalise prior knowledge and experience to apply them to work with clients in a forensic setting who may have atypical and complex presentations relating to mental health, social functioning and/or offending behaviour.
An ability to develop and maintain effective working alliances with service users, carers and professionals in a forensic setting, including service users who have a history of offending behaviour and/or who may be detained in hospital or receiving treatment about which they may feel ambivalent.
An ability to undertake a clinical risk assessment of harm towards others and follow risk management procedures within a forensic setting.
An ability to work safely with clients in a forensic setting, and to act within the limits of professional competence.
An ability to conduct assessments which vary in focus (e.g. mental health needs, offending behaviour), purpose (e.g. informing legal process, identifying treatment need), method (e.g. psychometric, structured interviews), approach (e.g. individual assessment, collaborative, MDT. indirect methods), and recipient (e.g. individual, service or court).
An ability to develop collaborative formulations within a forensic context with a range of presentations.
An ability to develop collaborative formulations to facilitate clients' understanding of their difficulties, to plan appropriate interventions, and to assist multi-professional communication within a forensic context.
An ability to select appropriate interventions to contribute to treatment directly (e.g. individual/group formats) and indirectly (e.g. consultation), and to evaluate the effectiveness of interventions delivered within a forensic setting.
An understanding of ethical issues, legal framework and legislation/guidance relating to clinical work within a forensic context, and an ability to reflect on the personal challenges and emotional impact of clinical work in a forensic setting.

DESIRABLE

An ability to choose, use and interpret a broad range of assessment procedures and third-party information to conduct a comprehensive assessment in the context of people where their offending behaviour is important.
An ability to conduct specialised structured risk assessments with offenders in a forensic setting (e.g. HCR-20).
An ability to develop collaborative formulations within a forensic context which are multimodal (e.g. draw on a range of models), multi-level (e.g. for use by individuals and other professionals), multi-domain (e.g. neuropsychological, behavioural, interpersonal, medical), and multi-purpose (e.g. for individual and multi-agency management plans).
Awareness of specialist interventions relating to offending behaviour (e.g. sexual offender treatment, violent offender treatment, arson interventions), risk behaviours, specific issues (e.g. substance abuse, anger management), and complex clinical needs.
An ability to adapt style of written and verbal communication for different audiences, and to demonstrate skills in relation to report writing within a medico-legal context.

These criteria are based on the BPS DCP Good Practice Guidelines for Training in Forensic Clinical Psychology (2007).

Core Clinical Competencies

BPS (2025) Standards for the accreditation of Doctoral programmes in clinical psychology

NINE core competencies are defined as follows:

1. Generalisable Meta-Competencies

a. Drawing on psychological knowledge of developmental, social, and neuropsychological processes across the lifespan to facilitate adaptability and change in individuals, groups, families, organisations, and communities.
b. Deciding, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with service users, carers, and service systems. These skills should be supported by competencies in clinical hypothesis testing which allows evaluation of alternative, competing explanations when considered against a broad evidence and knowledge base.
c. Being able to work within an anti-racist, anti-discrimination framework. This includes being able to work in an inclusive manner with individuals and groups who represent aspects of difference in beliefs, power, and lifestyle, visible and invisible, voiced and unvoiced.
d. Being cognisant of home nation legislation in relation to mental capacity, safeguarding, and frameworks associated with compulsory detention and treatment. This includes how this legislation and related processes are related to clinical care and clinical risk assessment and management, and, more broadly, clinical assessment, formulation, intervention and evaluation.
e. Being able to engage with, contribute to and support multi-professional and multi-agency collaborative working and learning.
f. Synthesising prior knowledge and experience in order to apply them critically and creatively in different settings and novel situations.
g. Familiarity with theoretical frameworks, the evidence base and practice guidance frameworks such as NICE and SIGN. This includes the ability to utilise these frameworks in complex clinical decision-making without being formulaic in application, and in combination with clinical judgement and informed service user choice.
h. Familiarity with relevant diagnostic structures and approaches to classification. Programmes should also provide opportunities in theory and practice to critically appraise diagnostic taxonomy and classification systems.
i. Complementing evidence-based practice with an ethos of practice-based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.
j. Knowledge of opportunities and limitations of digital practice and the ability to effectively provide services (including teaching, supervision, assessment, formulation, consultation and intervention with individuals, families, groups and multi-disciplinary teams) as well as undertaking research digitally.
k. Ability to collaborate with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.
l. Making informed judgments on complex issues in specialist fields, often in the absence of complete information.
m. Ability to develop and communicate psychologically informed ideas and conclusions to other stakeholders (specialist and non-specialist), in order to influence practice and facilitate problem solving and decision making.
n. Exercising personal responsibility, integrity and largely autonomous initiative in complex and unpredictable situations in professional practice. Demonstrating self-awareness and sensitivity whilst working as a reflective practitioner within ethical and professional practice frameworks.
o. Understanding and attending to planetary health in line with HCPC Standards of Proficiency and the requirement to 'understand how social, economic and environmental factors can influence a person's health and wellbeing'.

2. Psychological assessment

a. Developing and maintaining effective working alliances with service users, carers, colleagues and other relevant stakeholders.
b. Ability to choose, use and interpret a broad range of assessment methods appropriate:
    i. to the client and service delivery system in which the assessment takes place; and

ii. to the type of intervention which is likely to be required.
iii. Assessment procedures in which competence is demonstrated will include:
iv. detailed information gathering from individuals, couples, families, groups and services, and anyone else involved in supporting the service user,
v. recognition of the cultural and social context of service users and carers in line with FPS4 and FPS 5, in the application, administration and interpretation of all assessment procedures,
vi. performance based psychometric measures (e.g. of cognition, memory, development and performance),
vii. administration and interpretation of neuropsychological and psychometric tests that assess cognitive, memory and performance abilities. This practice must be observed,
viii. self- and other-informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours),
ix. systematic interviewing procedures,
x. ability to adapt an assessment to meet the cognitive and communication needs of an individual with an intellectual disability and/or Autism,
xi. other structured methods of assessment (e.g. observation, or gathering information from others); and
xii. assessment of social context and organisations.

c. Within the assessment process, having the ability to consider issues of relative power, social currency and the potential for the client to experience prejudice, discrimination and stigma (see FPS 6 in particular).
d. Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. reliability and validity, effect sizes, reliable change scores, sources of error and bias, base rates etc.) and utilising this knowledge to aid assessment practices and interpretations thereof. Consideration must be made of the cultural appropriateness of any assessment processes and the potential necessity for alternatives rather than adaptations.
e. Conducting appropriate risk assessments in the context of a formulation guided by the relevant evidence base and clinical theory and using this information to guide practice.
f. Capacity to provide all of the above digitally with awareness of the relevant risks and limitations.

3. Psychological formulation

a. Using an assessment to develop formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors.
b. Developing a formulation through a shared understanding of its personal meaning with the client(s) and/or team in a way which helps the client and/ or team better understand their experience.
c. Capacity to develop a formulation collaboratively with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.
d. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.
e. Promote, undertake and co-construct formulations within teams and systems, sharing them in oral and written forms. Develop skills to lead on the implementation of formulation in services, utilising formulation to enhance teamwork, multi-professional communication, and psychological mindedness in services.
f. Within the formulation process, having the ability to consider and apply understanding of the impact of issues of relative power, social currency and the potential for individuals to experience prejudice, discrimination and stigma.
g. Recognition of the structural inequity and cultural and social context of service users in considering appropriate theories applied in the formulation in line FPS 4 and FPS 5.
h. Constructing formulations utilising relevant theoretical frameworks. These should include the ability to adopt unimodal as well as an integrative multimodal, or pluralistic perspectives, also considering transdiagnostic processes as appropriate and adapted to circumstance and context.
i. Constructing formulations of presentations which may be informed by, but which are not necessarily premised on, medical diagnostic systems. Formulations should go beyond description and classification to develop and test hypotheses, inform understanding and decision making and guide delivery of appropriate interventions.
j. An ability to develop formulations in an emergent transdiagnostic context. An awareness of the utility of formulation in understanding team and organisational responses and behaviours as part of leadership activity.
k. Ensuring that formulations are expressed in accessible language, culturally appropriate and sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.
l. Critically reflecting on and revising formulations in the light of ongoing feedback and intervention.

m. Capacity to provide all of the above digitally with awareness of the relevant risks and limitations.

4. Psychological intervention

a. On the basis of a formulation, implementing psychological interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with:
    1. individuals,
    2. couples, families, or groups,
    3. services/organisations.

b. To undertake interventions which are informed by understandings of structural prejudice and stigma, power differentials and social inequity.

c. Demonstrate the capacity to understand and deliver therapeutic techniques and processes when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances, life events or trauma, homelessness, problem gambling, eating difficulties, psychosis, perinatal mental health, problematic substance use, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations, intellectual disability, physical disability and people who are neurodivergent, as well as complex and/or overlapping presentations.

d. To have the capacity to use their professional role to promote psychological wellbeing at a wider community and societal level as a psychological intervention.

e. Illustrate knowledge of and ability to use digital technologies directly and indirectly for delivering psychological interventions to individuals, families, groups or organisations. For example, offering psychological interventions by telephone and videocall and using apps.

f. Programmes must provide training in a minimum of two clinical therapy models one of which must be Cognitive Behavioural Therapy (CBT). The models chosen must provide trainees with the capacity to work with people with moderate to complex difficulties. Programmes may choose to use these models as a basis for developing secondary accreditation pathways, recognising the limits of the models and their respective evidence base.

g. Trainees must learn how to deliver psychological interventions in the absence of an appropriate evidence base, integrating psychological theory, research and principles from different perspectives to derive their intervention in such cases. They should have the knowledge of, and capacity to conduct interventions related to, primary, secondary prevention and the promotion of health and wellbeing. Attention needs to be given to:
    i. The ability to conduct interventions in a way which promotes recovery of personal and social functioning as informed by service user values and goals,
    ii. an awareness of the impact and relevance of psychopharmacological, medical and other multidisciplinary interventions,
    iii. an understanding of social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives,
    iv. knowledge and skills to implement interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements; and
    v. recognising when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively to service users and carers.

5. Evaluation

a. Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values, goals and clinical indicators (such as behaviour change and change on standardised psychometric instruments). It is essential that such approaches are clinically valid and are meaningfully informed by service user experience.

b. Devising and applying innovative evaluative procedures which are clinically meaningful, valid, and which support assessment of whether an intervention has achieved its aims or objectives, or which contribute to the process of formulation and hypothesis testing.

c. During evaluation, having the ability to consider how issues of relative power, social currency experience of prejudice, discrimination and stigma influence the evaluative process.

d. Capacity to utilise supervision effectively to reflect upon personal effectiveness, and shape and change personal and organisational practice being influenced by information provided by outcomes monitoring, including in relation to unexpected or unsuccessful outcomes.

e. Capacity to use and access feedback on professional activity from other professionals and peers, e.g. reflective practice groups, placement staff groups, personal and professional development groups.
f. Knowledge of the evidence base for digital practice and digital tools for evaluating client outcomes and experiences.
g. Ability to select and use valid and appropriate digital tools for clinical outcome monitoring, service evaluation and research.
h. Understanding outcomes frameworks in wider use within national health and social care systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and using this knowledge to adopt valid and meaningful evaluative strategies.
i. Appreciation of the strengths and limitations of different evaluative strategies, informed by knowledge relating to psychometric theory, indices of change, and concepts of reliability and validity. Such knowledge should be used in particular in clinical decision making to adopt evaluative strategies which are culturally informed (see FPS 5) and clinically meaningful.
j. Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.
k. **C**apacity to disseminate the outcomes to influence practice more broadly within the team, service, organisation and more broadly as appropriate.

6. Research

a. Being a critical and effective consumer, interpreter and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.
b. Conceptualising, designing and conducting independent, original and translational and/or foundational research of a quality to satisfy peer review, contribute to the knowledge base of the discipline, and which merits publication. This will include:
    1. understanding the epistemological approach and underlining assumptions,
    2. identifying research questions,
    3. demonstrating an understanding of ethical issues, choosing and undertaking appropriate research methods and analysis (both quantitative and qualitative), interpreting outcomes and
4. identifying appropriate pathways for dissemination.
c. A recognition that all research endeavours need to be meaningful and ultimately beneficial to participants and their wider communities, operating with co-production as a key principle in line with UK standards of research. Programmes should consider how to diversify and ensure inclusive and less excluding research processes which addresses the issues identified in FPS 5. This should include processes to enable marginalised/underrepresented communities and individuals to participate across the research process.
d. Understanding the need and value of undertaking translational and foundational (applied and applicable) clinical research post-qualification, contributing substantially to the development of theory and practice in clinical psychology.
e. The capacity to review research systematically and to conduct service evaluation, small N, pilot and feasibility studies and other research which is consistent with the values of both evidence-based practice and practice-based evidence.
f. Conducting research in respectful collaboration with relevant stakeholders, e.g. service users, peer researchers, supervisors, other disciplines and collaborators, funders, community groups etc. and within the ethical and governance frameworks of the Society, the Division, HCPC, universities and other statutory regulators as appropriate (see also FPS 6).

7. Personal and professional skills and values

a. A high level understanding of the application of principles of professional ethics and their application in complex clinical contexts. This should include knowledge of and evidenced adherence with relevant frameworks of professional ethics (including the BPS Code of Ethics and Conduct and the HCPC Standards of Conduct, Performance and Ethics) in all relevant clinical, professional and research settings.
b. Awareness of the principles of informed consent and shared decision making which underpins all contact with service users and research participants
c. Appreciating and attending to the inherent power imbalance between practitioners and service users and carers and how abuse of this can be minimised.

d. Understanding the impact of racism and discrimination on people's lives and actively working within an anti-racist and anti-discrimination framework (see FPS 6).
e. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices (see FPS 4 and FPS 5).
f. Understanding the impact of one's own value base, privilege and power upon clinical practice, including one's own conscious and unconscious biases and prejudices.
g. Knowledge of ethical dimensions which arise from the use of digital technologies. Awareness of one's own attitudes, skills and values regarding digital practice and the capacity to reflect on these.
h. Working effectively at an appropriate level of autonomy, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.
i. Capacity to adapt to, and comply with, the policies and practices of both the employing organisations and University with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.
j. Managing own personal learning needs and developing strategies for meeting these. Utilising self-directed reflection, discussion with peers and using supervision to reflect on practice and making appropriate use of feedback received.
k. Developing strategies to handle the emotional and physical impact of practice and seeking appropriate support, when necessary, with good awareness of boundary issues.
l. Developing resilience but also the capacity to recognise when one's own fitness to study or practice is compromised and take steps to manage this risk as appropriate to ensure practise remains safe and effective.
m. Recognising and attending to the power dynamics and potential conflicts within relationships with colleagues and peers (see also FPS 2).
n. Working collaboratively and constructively with fellow psychologists, trainees and other colleagues and users of services, respecting diverse viewpoints and differences in opinion.
o. Knowledge of clinical governance, which should include assessed knowledge of the principles organisational ethics, quality control, quality assurance and quality improvement methodologies, and an understanding of how both quantitative metrics and qualitative user feedback are critical to the provision of safe services. The principles of clinical governance also need to be considered within digital practice and professional contexts in relation to digital practice, including digital record systems, risk management, clinical safety online, information storage and sharing.
p. Knowledge of research ethics and governance, which should include Health Research Authority policies regarding information governance and digital training.
q. Ability to assess capacity and obtain a client's informed consent in both a clinical and research context, an understanding of the principles of confidentiality and circumstances where this may be breached, and the ability to engage effectively with formal safeguarding procedures.

8. Communication And Teaching

a. Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).
b. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and differences in sensory processing and modes of communication.
c. Understanding the process of communicating effectively through interpreters and having an awareness of the benefits and limitations of working in this way.
d. Communicating in an inclusive, non-discriminatory manner, taking into account issues of power, privilege and difference, in line with the FPS.
e. Capacity to write detailed and, often technical, reports that clearly communicate complex information in a readable and comprehensible style relevant to a range of different audiences.
f. Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content) and the medium of delivery (face-to-face, telephone or online). This should include in-person and digital training related to clinical practice and psychoeducation and awareness of both synchronous and asynchronous methods of training delivery.
g. Knowledge of how digital practice affects communication processes (e.g. turn taking and use of non-verbal information).
h. Understanding of the supervision process for both supervisee and supervisor perspectives.

i. Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.
j. Supporting others' learning in the application of psychological skills, knowledge, practices and procedures.

9. Organisational And Systemic Influence and Leadership

a. In line with the Foundational Programme Standard, awareness of the structural inequalities within organisations and services and the capacity to address these where possible, particularly utilising anti-racist/anti-discrimination frameworks of practice.
b. Awareness of the models of leadership and the role of leadership practice and influence on organisational culture and functioning, particularly with regards to ensuring anti-discriminatory, psychologically safe and inclusive work environments and services.
c. Working with users and carers to facilitate their involvement in service planning and delivery.
d. Awareness of the legislative and national planning and commissioning contexts for service delivery and clinical practice.
e. Capacity to adapt practice to different organisational contexts for service delivery. This should include a variety of settings such as in- patient and community, primary, secondary and tertiary care.
f. Awareness of issues in working within community and third sector settings to promote psychological thinking.
g. Awareness of utilising systemic influence and leadership skills to promote change at a preventative stage, including within a public health setting.
h. Ability to act as a positive role model by demonstrating an open and curious approach to the adoption of innovative digital ways of working.
i. Providing supervision at an appropriate level for own sphere of competence.
j. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross- professional teams. Bringing psychological influence to bear in the service delivery of others.
k. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities and competencies such as being aware of and working with interpersonal processes, the need for proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.
l. Understanding of change processes in service delivery systems.
m. Understanding and working with quality assurance principles and processes including informatics systems which may determine the relevance of clinical psychology work within healthcare systems.
n. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.