CBT Competence List for E-Portfolio

In October 2015, The British Psychological Society released a revised set of *Standards for Doctoral Programmes in Clinical Psychology* (British Psychological Society Partnership and Accreditation Team, 2015). Although some minor revisions are described in a range of areas, the main focii of the new Standards are; promoting and emphasising the over-arching competencies to deliver tailored, multi-modal and often complex, psychological interventions; increased credibility that specific knowledge and skills have been obtained through transparent benchmarking of work against recognised competence frameworks; and incorporating systematic approaches to *in vivo* assessment to further quality assure competence development.

In recent years, the programme has developed a clear curriculum for the delivery CBT theory and techniques. This would include teaching in the general principles of CBT, and disorder specific models, throughout the programme with an emphasis in year one. During year one, trainees take part in a range of workshop based sessions which culminate in two “role play” days involving paid actors, experienced local clinicians and service users, all of whom provide trainees with formative feedback on their performance. One of these sessions focuses on the initial assessment process, while the second has a focus on formulation. Trainees have their session video recorded and are able to review their own performance.

Within the placement context, in collaboration with National Health Education for Scotland (NES), a range of initiatives are have been developed which will ensure competence development is evaluated in a consistent and systematic manner and that the progress is recorded in a more coherent and transparent fashion. These include:

1. Training in CBT Supervision and the use of structure tools in the evaluation of CBT skills:

A CPD resource has been developed that involves an online component describing models of CBT supervision, followed by a one day face to face event which expands on these models, describes the importance of “in vivo” evaluation, and offers the opportunity to practice using CTS-r in the presence of experienced users. The module also involves a 3 month follow up contact which asks supervisors to describe how they have implemented the learning.

1. Specialist training in CBT supervision for CYP:

A training module, based on the format described above has been developed specifically for supervisors working in a CAMHS environment. Several structured tools are introduced.

1. Increasing awareness of the need to use structured tools (eg CTS-r) in the evaluation of trainee competence:

Through our existing communication channels (supervisor sub group, annual supervisor day, placement meetings, regular direct communication with supervisors) we will continue to promote the use of structured tools. Raising awareness has already had some impact over the last year: recorded incidence of the use of CTS-r in 1st year AMH placements has grown from a very low level to almost 120 CTS-r ratings by supervisors in the 2014-15 academic year as reported through EPD. From the 2016 intake, we will be requiring trainees to ensure they receive formative feedback of at least 3 CTS-r rated sessions by supervisors and that they self rate a further 2 sessions using CTS-r.

1. Development of an ePortfolio system allowing more transparent and systematic recording of evidence of competence.

To guide supervisors and trainees further in the planning, evaluating and recording of CBT competence development, a list of key competences has been distilled from a range of existing and recognised competence frameworks including Cognitive Behaviour Therapy Competence Framework developed by Roth and Pilling (UCL 2007) and from the BABCP Minimum Training Standards (McDonald & Haddock 2012). Guidance is also given on the range experiences that we would expect trainees to gather to ensure sufficient breadth and depth of experience in delivery of CBT across presenting difficulties and stage of treatment.

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| **Competence List** | |
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| **Knowledge** | |
| Knowledge encompassing a broad based understanding of the theoretical basis of Cognitive and/or Behavioural Therapy and the evidence base for CBT across a range of conditions\*\* | |
| Knowledge of basic principles of CBT and rationale for treatment across a range of conditions | |
| Knowledge of common cognitive biases, and other cognitive features relevant to the maintenance of common psychological disorders | |
| Knowledge of the role of safety-seeking behaviours and other behaviours relevant to the maintenance of common psychological disorders | |
| Knowledge of appropriate outcome measures and self-monitoring techniques relevant to CBT | |
| **Skills** | |
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| *Overarching CBT skills* | |
| Ability to implement CBT using a collaborative approach\* | |
| Ability to use a guided discovery approach, including the use of Socratic questioning\* | |
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| *Basic CBT Skills* | |
| Ability to explain and demonstrate rationale for CBT to client\* | |
| Ability to agree goals for the intervention\* | |
| Ability to structure sessions (using agenda setting, summaries and homework planning and review) \* | |
| Ability to use two-way feedback throughout therapy\*\*\*\* | |
| Ability to develop collaborative CBT formulations appropriate to the stage of therapy (and to use these to develop treatment plans) \* | |
| Ability to implement a problem-solving approach\* | |
| Ability to end therapy in a planned manner, and to plan for long-term maintenance of gains after treatment\* | |
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| *Specific BT and CT skills* | |
| Ability to elicit key cognitions (appropriate to stage of therapy i.e. automatic thoughts, assumptions and core beliefs) \* | |
| Ability to elicit key behaviours (including safety behaviours, avoidance, withdrawal, overactivity)\* | |
| Ability to choose and implement appropriate cognitive change techniques (e.g. thought diaries, self-talk, positive data logs, continua, thought acceptance) \* | |
| Ability to choose and implement appropriate behavioural methods to facilitate change (e.g. exposure (imaginal, in-vivo or interoceptive), activity scheduling, behavioural experiments, role-play, response prevention, modelling) \* | |
| Ability to elicit and work with imagery | |
| Ability to elicit appropriate emotional expression\*\*\*\* | |
| Ability to manage client’s emotions appropriately within the session\*\*\*\* | |
| Ability to promote self-management of maladaptive mood and arousal out with the sessions (e.g. emotion regulation strategies, applied relaxation, breathing retraining, mindfulness work) \* | |
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| **Competences in the adaptation of CBT** | |
| Capacity to adapt and flexibly apply CBT formulations and interventions, to take into account the needs of the individual client. This includes: | |
| Ability to adapt CBT skills to two or more different Specialist Populations\*\*\* | |
| Ability to carry out Consultation or indirect working informed by evidence-based CBT theory and techniques\*\*\* | |
| Ability to apply CBT in at least two different service delivery contexts\*\*\* | |
| Ability to apply CBT with clients with a range of common mental health problems and a range of severity and duration of difficulties\*\*\* | |

\* drawn from the Roth & Pilling Competence framework

\*\* drawn from the BABCP Minimum Training Standards

\*\*\* Informed by CTCP criteria and the HCPC SoPs for Practitioner/Clinical Psychologists

\*\*\*\* Informed by Cognitive Therapy Scale-revised

**Trainee Experience Checklist:**

1. Substantial supervised CBT assessment and therapy experience (exceeding 200 hours).
2. Minimum eight CBT cases across training, which have had a primary CBT focus during assessment, formulation and/or treatment (including one-to-one treatment, group treatment work with families, couples or carers and indirect work with carers/staff).
3. A minimum of four cases will have been seen for assessment, formulation and treatment. The remaining four cases must involve two cases where the trainee has conducted assessment, leading to formulation (but need not have completed treatment) and a further two cases where the trainee has delivered CBT treatment (but need not necessarily have undertaken the initial assessment) - for example, where initial assessment has taken place in the MDT context and trainee is involved in providing a discrete piece of CBT therapy.
4. Face-to-face individual CBT supervision (possibly supplemented by group supervision) proportionate to the number of CBT assessment/therapy hours.
5. Formal feedback on at least 3 CBT cases based on live observation, audio or video materials, using a standardised method (e.g. CBT competency scale); demonstrating an acceptable standard of competency, appropriate to stage of training.
6. Experience treating a range of psychological problems with CBT, including mood and anxiety disorders.
7. Experience using a range of evidence-based CBT treatment approaches; must include experience with both cognitive and behavioural elements (or combined cognitive- behavioural work).
8. Self-directed study on CBT theory and skills, including research (will exceed 250 hours)

British Psychological Society Partnership and Accreditation Team (2015) *Standards for Doctoral Programmes in Clinical Psychology*. The British Psychological Society: Leicester.

Health and Care Professions Council (2015) *Standards of Proficiency: Practitioner Psychologists*, Health and Care Professions Council, London

McDonald & Haddock (2012), BABCP Minimum Training Standards For the Practice of Cognitive Behavioural Therapy

(CBT), BABCP. Available at: <http://www.babcp.com/files/Minimum-training-standards-V6-0413.pdf> [accessed 18th August 2016]

University College London (2016)  *Competence Frameworks, UCL: London.* Available at:<http://www.ucl.ac.uk/pals/research/cehp/research-groups/core/competence-frameworks> [*accessed 9th August 2016}*