**Requirements**

The purpose of this assessment is to assess competencies as evidenced through the write up of an extensive piece of clinical work. This section aims to provide guidance about writing up the Clinical Activity Report (CAR) and systems that are in place to support the production of these reports.

Trainees are required to submit two CARs over the course of their training, in addition to one Clinical Process Report (CPR). Each of these three reports (two CARs and one CPR) must be based on clinical work from separate placements. If a trainee is on a year-long placement then these reports can come from either of the six-month periods of the placement. The material used for the CAR/CPR should not be used for anyother assignment, ie orals. **The maximum word limit for each report is 5,000 words.** **Markers must be able to read the report without reference to the appendices, which should provide only supplementary information.** Trainees should normally write their CAR/CPR from the placement they are on at the time of submission. The submission times and required focus are as follows:

**CAR/CPR Submissions**

|  |  |
| --- | --- |
| **Year of Training** | **Client Group** |
| 1 | Adult or Older Adult |
| 2 | Children/Families OR Learning Disabilities |
| 3 | Specialty Placement |

The three reports (two CARs and one CPR) should represent a broad range of work that has been undertaken by the trainee. Therefore, trainees would be expected to select clinical work that shows diversity in terms of, for example, client characteristics, presenting problem, theoretical model used and level of intervention.

The following sections give detailed guidance on the structure and contents of the CAR.

**Focus and aims**

The Clinical Activity Report (CAR) gives you an opportunity to demonstrate that you can write-up a clear and coherent account of a piece of clinical work that you have undertaken in supervised clinical practice. As part of this task, you are expected to show how you have made theory-practice links throughout the work that you have done. You are expected to refer to current policy and relevant clinical practice literature. Make sure that you are explicit about your clinical reasoning in relation to the piece of work you write about, including how you have evaluated and reflected on the work and issues raised. This assignment gives you an opportunity to show how you have applied and developed your clinical competencies in practice. The marking grid for this assignment gives further information on the areas that are being assessed, and it is recommended that you familiarise yourself with this in preparation for writing up your report.

You are not expected to write-up a ‘perfect’ case example. Challenging clinical work provides a rich source of material from which to learn, reflect and improve as a clinician. You are encouraged to use the support of your personal tutor and (where possible) your clinical supervisor, as well as clinical seminars, to help you plan which piece of clinical work you choose to write up. The structure of the report gives you ample opportunity to reflect on aspects that did not go so well, as well as those that did. It is not just what you have done, but the way that you rationalise and reflect on what has happened, that is important.

In summary, the report needs to tell a coherent story that shows your competency in integrating theory, research and evidence-based practice in relation to the specific needs of your specific client at this juncture in their lives. You will need to be explicit about the rationale for what you do throughout (e.g., why you conducted the assessment in the way that you did; how you arrived at your theoretically informed formulation; why you choose to evaluate progress in the way that you do). It is expected that there will be a logical linkage between the different sections in the report (assessment, formulation, action planning, intervention and evaluation), and that the report will read fluently.

**Client consent and confidentiality**

Because you will be basing your report on a real piece of clinical work, it is essential to obtain written informed consent from the client (and/or responsible adult). You should submit to [dcpadmin@essex.ac.uk](mailto:dcpadmin@essex.ac.uk) a signed consent form from the client or alternatively a form from your supervisor indicating you have consent to present this client for your university assignment. This should be submitted to admin no later than the Thursday prior to the submission date. See section on consent forms. You are expected to fully anonymise the report (including all appendices) by protecting the identity of the client and disguising any other identifying information. This means removing all identifying information such as: names; date of birth; Trust/service names and addresses; names of colleagues. Very particular information about the client may need to be disguised or omitted. A statement of anonymity needs to be included on the title page of the report. Lack of anonymising is considered to be a serious academic offence and can lead to failure on the assignment.

**Structure of the Report:**

In the event that it is necessary to deviate from the normal structure (outlined below) please clearly signpost to the marker where, and why you have done this.

***Title Page***: This needs to include the following:

A clear and relevant title (e.g., using a Cognitive Approach to Working with a Bereaved Client with Generalised Anxiety).

Your candidate number and the reference for the assignment (e.g., CAR 1 or CAR 2)

A statement of anonymity

A word count (not including abstract, references & appendices).

***Abstract*:** A short abstract of the case to be described should be included (no more than one brief paragraph). This will include a summary of the client, the type of work undertaken - and a sentence on the outcome.

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***Referral*:** Give a brief synopsis of how the referral came about (e.g., who was referred by whom and why).

***Assessment:*** In this section an account is given of the assessment strategy (e.g., what the aims of the assessment are; the rationale for how information is to be gathered) including a summary of the different information sources used (e.g., case notes; standardised assessments; observations; medical diagnosis; meetings with clients; meetings with involved others). Always make clear what role you have played in actively eliciting information, and when information has been gathered by others. Remember to reference any standardised assessment tools used, and report interpretations as well as scores. In this section the relevant information is brought together in order to give a detailed account of the client’s presenting difficulties (e.g., severity; frequency; impact; triggers); current situation (e.g., social networks; occupation) and relevant history (e.g., significant relationships, formative experiences, history of the problem). It is also important to be sensitive to the way in which the client presents and engages with services, and what their views about the nature of their problems are. It can also be helpful to highlight gaps in assessment information, and reasons for this. This section leads into the formulation section of the report.

***Formulation*:** This is a pivotal section of the report, from which the action plan and intervention will flow. This section brings together the assessment information in a way that begins to make psychological sense of the client and the problems they present with. Crucially, it links information about the client with the salient theoretical and clinical literature.

Formulations will vary from client to client and depending on the theoretical perspective(-s) that most inform them. It will be possible to formulate fairly clearly with some pieces of work, and only more tentatively with others. However, essentially the formulation is a series of connected hypotheses about the origin and maintenance of the client’s problems. Unlike more general theories or models, the formulation will be anchored in the experiences of the client and based on clinical observation (rather than being overly abstract). It is the vehicle through which theory and clinical literature dovetail with the specific presentation of the particular client(-s). The formulation can help to identify maintenance factors in a way that indicates potential avenues for psychological intervention. It can also be helpful to represent formulations diagrammatically.

It will be helpful as part of this section to briefly summarise any salient psychological literature that links the client’s focal problems to a psychological framework. It is also essential to look fairly specifically at how the client’s current difficulties can be understood within a psychological framework(-s) so that it is possible to develop a client centred account.

***Action Plan*:** This section needs to follow logically from the assessment and formulation sections, and to be clearly anchored in the client centred formulation. The action plan needs to make sense given the information available about factors that appear to be perpetuating the problem. It is important to tailor the plan closely to the individual client, and not just adopt an ‘off the peg’ clinical approach. The action plan will include an outline of the agreed goals of therapy, and it can be useful to hear how plans for therapy are discussed or negotiated with the client. Reference does need to be made to existing clinical guidelines (e.g., NICE) and relevant outcome literature. If you adopt an approach that is not in keeping with ‘mainstream’ practice (where it exists), then clearly communicate your rationale for why you have chosen the treatment path that you have, and justify it.

The action plan may include a decision to work on process issues (e.g., engagement) or to extend assessment. It may reflect a decision to work indirectly with staff/carers. It may involve an outline of a therapy ‘plan’. Whatever course of action is chosen, it needs to be clearly justified. It is also helpful to highlight ethical and professional considerations raised by the work, and to outline plans for monitoring/evaluating the progress of the work.

***Intervention:*** A clear account of the work undertaken needs to be given in this section. However, this does not need to be a ‘blow by blow’ account. Care will need to be taken in structuring this section in order to synthesise the information and communicate it clearly. It is important to continue to demonstrate the link between theory and practice and to relate the procedures used back to the formulation. It is useful to hear about the process of the work (e.g., management of ‘therapy interfering’ issues) as well as the actual content of what was done. Where there has been joint work or liaison with other colleagues, include reference to this. It can help to bring this section to life if you choose careful illustrations, such as quotes from the client – and your own clinical observations. Where you have adapted standard techniques (e.g., your own version of a thought diary) describe how you have done this, and consider including an example as an appendix. Overall, this section gives you an opportunity to write in a way that shows your clinical thinking and competencies.

***Outcome and Follow-Up:*** In this section information is presented about what was achieved in working with the client. This will relate back to the evaluation strategy that is outlined as part of your action plan. Think about ‘informal’ accounts of change (e.g., feedback from clients, your own observations) and more ‘formal’ measures of change (e.g., questionnaires; baseline recordings). Bring different sources of information together in order to review and evaluate any changes that have occurred in response to the therapy. Consider if the initial goals of therapeutic work have been met or not. If change is limited or less than expected, reflect on why this might be. Where there is change, think about how significant this is (e.g., changes on questionnaire measures may not correlate with qualitative ‘life’ improvements). If the work conducted has mainly involved consultation to others (e.g., recommendations following an extended assessment) then consider what the impact of this has been. If there are evaluation tools you could have used, but didn’t, you may want to comment on this here too.

If there are plans for follow-up, or if you are developing ‘relapse prevention plans’ or ‘blueprints’ with the client, mention this work here too. If new insights and new information have come to light during the course of therapy that significantly change the way in which you are able to make sense of your client, include a review of the original formulation – and present a reformulation if necessary.

Overall, this section provides an opportunity for you to reflect critically on the piece of clinical work that has been done, and to evaluate it in a balanced and thoughtful way.

***Critical Review and Reflective Account:*** This section of the report affords you the opportunity to reflect on the clinical work in a broader sense. It is useful to reflect on the overall strengths and weaknesses of the work that was done, and on what you might choose to do differently in the future. Think about the particular professional and ethical issues that were raised (e.g., consent; multi-disciplinary working; use of supervision). How did issues of diversity and context impact on the work? Reflect on the impact of the work on you, and your own learning in relation to the case (including ongoing competency development needs) – highlighting any future continuing professional development (CPD) needs that it may raise for you.

***References:*** Give a reference list for all sources cited in the body of the report, using the APA style guide.

***Appendices*:** The appendices **must** include:

One example of a report/clinic letter prepared by the trainee

The appendices **may** include:

Examples of records used (e.g., thought diaries; mood monitoring).

Examples of hand-outs or information leaflets used

Examples of working formulations shared in sessions.

Examples of measures used.