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The vignette-matching procedure: An innovative approach to assess competencies in psychology and clinical practicum. Final Report.

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**The Vignette-Matching Procedure:
An innovative approach to assess competencies in
psychology and clinical practicum**

Final Report 2012

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**The University of New South Wales
Macquarie University
University of Western Sydney
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Craig Gonsalvez (Report Author)

**[http://www.uow.edu.au/health/iimh/vignette-
matching/index.html](http://www.uow.edu.au/health/iimh/vignette-matching/index.html)**

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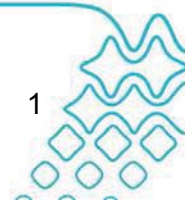
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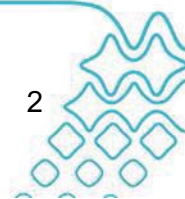
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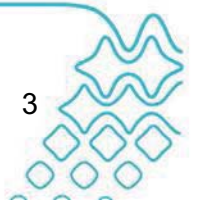
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List of Acronyms

ALTC – Australian Learning and Teaching Council Limited

CERF – Competency Evaluation Rating Form (generic)

CΨPRS – Clinical Psychology Practicum Competencies Rating Scale

EPR – End-Placement Review

MPR – Mid-Placement Review

VMP – Vignette-Matching Procedure

Key Terms

Field Placement: The term is used in an inclusive manner, and refers to postings (usually a few months) of students undergoing professional training to diverse agencies to conduct professional work under supervision. Alternative terms include 'clinical rotations', 'field practicum', 'internships' (often of one-year duration), and 'externships'.

Field supervisors: The term is used in an inclusive manner, and refers to qualified agency professionals, often approved by training institutions and accrediting bodies, who provide training and professional supervision to students during their placements in the agency. Alternative terms used in the literature include 'clinical supervisors', 'clinical tutors', 'field instructors', and 'preceptors'.

Executive Summary

The Vignette-Matching Procedure Project (PP10-1624) has been a one-year, ALTC-funded project (\$105,000) to examine whether there was substance to growing concerns that ratings by university and field supervisors of practicum competencies were affected by a range of rating biases, and to trial an innovative approach to assess clinical practicum competencies in psychology – the use of standardised vignettes in lieu of competency-evaluation rating forms. In this multi-site research venture, six universities contributed to the generation of project resources, and five universities contributed data to the project.

Mid and end-placement data collected over a year from university psychology clinics and field placements strongly indicated that supervisor ratings were affected by leniency and halo biases. Further, several changes designed to reduce these effects failed to make appreciable differences to ratings.

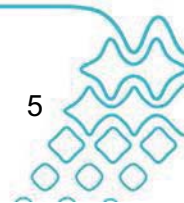
The key contribution of the project includes a compilation of a catalogue of 41 vignettes that represent nine domains of competence across several developmental stages for each domain. Individual vignettes were designed by experts and subjected to a rigorous process of peer-review and revisions, before final vignettes were formulated. The final vignettes were standardised by having a group of experts provide calibration scores that anchored each vignette to a specific point along a 10-point continuum ranging from unskilled beginner to competent professional. Finally, university and field supervisors used the conventional rating scale and the vignette-matching procedure (VMP) to evaluate competencies at end-placement. Data from a pilot and a follow-up study demonstrate that compared to conventional competency rating forms, the VMP reduces rater bias and significantly improves the reliability and validity of competency assessments in field placements.

Finally, perhaps the most valuable contribution is that the vignette-matching procedure yields a matrix of calibration scores across competency domains and stages of development. These calibration scores may be employed as a matrix of reference points against which competence may be graded. In effect, for the individual, calibrated vignettes provide a set of relatively stable anchors that help mark progress (or lack thereof) over time. At a macro level, calibrated vignettes provide a framework to benchmark and to compare performances of cohorts of students across institutions and time. Further, because sets of vignettes may be normed separately for different contexts and countries in the same way as intelligence tests, calibration scores give the vignette-matching procedure versatility and impact.

The project's impact has exceeded expectations, resulting in invited presentations and expressions of interest for collaboration at national and international forums. The project's work has been disseminated in many different ways, including through seven conference presentations and four scientific journal articles. Selected examples of conference presentations and manuscripts are given below (see Dissemination section of the report for complete lists).

Selected conferences presentations and journal articles

1. Gonsalvez, CJ, Knight, R, Nicholson Perry, K, Shires, A, Allan, C, Blackman, R, Bushnell, J, Hyde, J & Nasstasia, Y 2011, 'Rating clinical competencies in externships. Can we enhance training outcomes?', invited presentation at the Clinical Psychology Curriculum Conference, Brisbane, 20-21 May 2011.

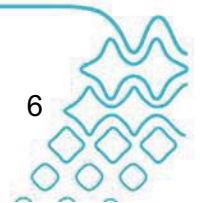


2. Gonsalvez, CJ, Shires, A, Allan, C, Knight, R, Nicholson Perry, K., Blackman, R, Webster, R, Hyde, J, Bushnell, J & Nasstasia, Y 2011, 'A multi-site study on the assessment of clinical psychology competencies by field supervisors: should vignettes replace rating scales?', paper presented at the Seventh International Interdisciplinary Conference on Clinical Supervision, Adelphi University, New York, 8-10 June 2011.
3. Gonsalvez, CJ, Nasstasia, Y, Shires, A, Allan, C, Nicholson Perry, K, Knight, R, Hyde, J, Bushnell, J, Blackman, R, Deane F & Bliokas, V 2011, 'The vignette procedure as an instrument of competency measurement: preliminary results and future directions', invited presentation at the Annual Psychology Clinic Directors Conference, Auckland, New Zealand, 25-26 November 2011.
4. Gonsalvez, CJ, Bushnell, J, Blackmann, R, Deane, F, Bliokas, V, Nasstasia, Y, Nicholson Perry, K, Allan, C, Knight, R & Shires, A, 'Assessment of psychology competencies in field placements: standardized vignettes reduce rater bias', manuscript submitted to Teaching and Education in Professional Practice.

Web-based deliverables

1. The project homepage, which hosts links to all participating institutions' versions of the CΨPRS, is available at:
www.uow.edu.au/health/iimh/vignette-matching/index.html
2. The CΨPRS mid-placement assessment instrument is available for trial by universities within and outside Australia at:
https://uowpsych.us.qualtrics.com/SE/?SID=SV_2fcZT2Cyept6CWM
3. The CΨPRS end-placement assessment instrument is available for trial by universities within and outside Australia at:
https://uowpsych.us.qualtrics.com/SE/?SID=SV_cMheOezW9tlXbzm
4. The Vignette-Matching Procedure instrument is available for trial by universities within and outside Australia at:
https://uowpsych.us.qualtrics.com/SE/?SID=SV_0TXBDjDryNVueFK&SSID=SS_aeYIxWhi7x9MW1e

In brief, the project demonstrates that the use of competency-rating forms, which are currently employed widely within psychology and other health disciplines both nationally and internationally, is flawed, being vulnerable to leniency and halo rating biases. A suite of standardised vignettes, generated by rigorous scientific procedures, have yielded improved assessment outcomes. The use of vignettes is an innovative procedure and has excellent potential to generate systemic improvements in assessment outcomes for psychology and other disciplines. Further research into the development and application of this innovation is a priority that warrants support from education and other sectors



Project Outcomes and Impact

The project has made excellent progress, delivered on outcomes promised, and in some instances exceeded set targets. The project proposal identified the project's main outcome as "the improvement of practicum assessment standards and assessment outcomes for psychology students," and listed four specific project outcomes or milestones that would indicate progress towards attaining it:

1. Enhancing critical awareness among university staff and field supervisors of the principles, limitations and possible solutions governing current assessment practices of clinical psychology competencies;
2. Designing, evaluating and standardising a new rating scale to measure clinical psychology practicum competencies;
3. Testing an innovative approach to assessment by designing, evaluating and standardising a catalogue of vignettes for assessment of psychology practicum competencies; and
4. Improving the reliability and validity of supervisors' end-placement assessments by conducting a landmark, multi-centre study that will systematically evaluate the strengths and limitations of current methods of assessments with the new vignette-matching procedure.

The project outcomes and impact will be discussed under each of these four steps.

Outcome 1: Enhancing staff awareness of critical issues affecting current assessment of clinical psychology competencies

The delivery of professional training in psychology comprises a number of facets that are crucial for professional preparation. In parallel with the training requirements of most professional training in other disciplines, academic coursework constitutes only one component of the professional-training landscape. The integration of theoretical knowledge into professional practice is an essential aspect, and is usually accomplished by practicum work. For psychology in Australia, practicum training typically entails an initial placement within a university psychology clinic (internal placement) followed by placements across several agencies that deliver psychological services (external placements). Students' practicum work is closely supervised during this training phase, with university clinic supervisors overseeing internal placements, and field supervisors monitoring external placements. Similar training models are employed by most other health professions, although the terms used may vary.

Because field supervisors have considerable experience and expertise and directly observe a student's performance across a range of real-life situations over time, supervisor assessments have often been accorded a high level of credibility (Gonsalvez & Freestone 2007). Unlike assessments conducted within an academic institution, field supervisors' judgments about clinical competence have high ecological validity. Consequently, their assessments are given serious consideration in determining whether the student passes or fails the placement, and more globally, whether the student is capable of attaining standards of competence.

To monitor and evaluate the performance of a student during placement, supervisors employ a wide variety of methods, including direct observation, observation of video recordings of case-work, case discussions, role plays and evaluation of case reports. At end-placement, supervisors usually complete competency evaluation rating forms (CERF). A sample set of items for one of the skills domains is presented in Table 1. Similar forms, although they vary in terms of length and response format, have been widely used for several decades, both within



psychology and several other health disciplines, both in Australia and internationally (Baird 2005; Gonsalvez & Freestone 2007; Kaslow et al. 2009; Tweed, Graber & Wang 2010). The popularity of the CERFs is easy to understand. They are user-friendly, inexpensive to administer, easy to score, and are sufficiently versatile to measure a range of global and specific competencies.

Table 1 – Items from CΨPRS domain 1, with visual analogue rating system

Domain 1 – Relational Skills	Rating			
	Stage 1	2	3	Stage 4
Overall – Includes ability for empathic understanding, application of basic counselling techniques and collaborative goal formulation with clients.	●—————●			
a) Ability to form and communicate an empathic understanding to clients, carers and significant others.	●—————●			
b) Ability to apply basic counselling techniques appropriately including clarification, paraphrase and summarisation responses.	●—————●			
c) Ability to use active and responsive listening skills.	●—————●			
d) Ability to formulate client goals in a collaborative manner.	●—————●			

Although they are popular, a growing body of evidence raises major concerns about the reliability and validity of CERF-type ratings (Borders & Fong 1991; Gonsalvez & Freestone 2007; Robiner et al. 1997). The results are consistent with the interpretation that systematic halo and leniency biases affect these ratings. Further, similar concerns about end-placement supervisor judgments have been raised in other health disciplines including social work (Bogo et al. 2002; Bogo et al. 2004; Lazar & Mosek 1993), medicine (Williams, Klamen & McGaghie 2003) and nursing (Chambers 1998; Dolan 2003). Inaccurate ratings, particularly those that are too lenient, reduce opportunities for trainees to develop their skills, and may ultimately erode public confidence if practitioners are ‘credentialed’ without attaining competence. The leniency bias could foster inflated self-perceptions and prevent necessary and appropriate remediation strategies. Robiner et al. (1997) concluded, “It may not be an exaggeration to consider the existence and extent of supervisory bias to be the most critical quality assurance issue confronting clinical psychology....” (p. 62).

Approach and methodology

Over several decades, CERF ratings have constituted the main instrument for end-placement evaluations of student competencies in psychology in Australia. The recent past has witnessed a significant increase in the number of domains and items included in CERFs. However, despite concerns from several quarters, essential aspects of the instrument have remained unchanged. Raising awareness of these issues among field supervisors and training staff is an essential step towards generating change in assessment practices. The current project included a systematic program of dissemination that included priming, informing, highlighting and consolidating key aspects of the message to relevant stakeholders. University psychology clinic directors and practicum coordinators have significant professional



practice and clinical supervision expertise, and are at the helm of practicum training in psychology. The dissemination strategy was specifically directed to this group and involved three types of activities: project activities, conference and workshop presentation and articles in scientific journals.

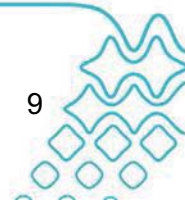
Project activities. The project had gained valuable support by recruiting as partners six clinic directors/placement coordinators from six universities in New South Wales. At the beginning stages of the project, the project team convened a workshop for the purpose of identifying and discussing the limitations associated with current assessment practices of practicum competencies, and in seeking solutions to the inadequacies. Each of the university representatives played a pivotal role in driving the project forward and ensuring that its momentum was maintained over the year. The university representatives were also actively engaged in networking activities, regularly updating other colleagues and field supervisors on the project's status, and inviting participation in the research activities of the project. Professional-development forums conducted by individual institutions for their field supervisors were also used to generate discussions about the problems associated with existing competency-assessment practices in clinical psychology.

Conference and workshop presentations. The dissemination of the project's work at national and international conferences has been particularly successful in garnering widespread interest in the project, and in developing key relationships within psychology and other health-related disciplines. The annual Psychology Clinic Directors Conference was specifically identified as a key forum for the success of our dissemination and implementation initiatives. Prior to the project's commencement, a conference presentation at this forum primed the group to the issues relating to problems currently associated with assessment practices of practicum competencies (see item 1 in the Dissemination section). A follow-up presentation at the same forum, this time by invitation of the conference organising committee, was made a year later (November 2011; see item 7 in the Dissemination section); a future presentation (November 2012) is also planned.

It was necessary to network extensively over the course of the year, both nationally and internationally. The project's activities were reported in an international conference in the USA (item 3) and in a workshop for field supervisors in the UK (item 6). Further, given that similar competency-assessment practices are used in other health-related disciplines, an inter-disciplinary approach was adopted. The forum with the most potential for cross-disciplinary impact is the annual international and interdisciplinary conference on clinical supervision. A presentation was made at the seventh sitting of this conference in New York to a range of professionals from nursing, social work, occupational therapy, counselling, psychiatry and psychology (item 3). In summary, a total of seven papers were presented at six different conferences, including three presentations overseas (see the Dissemination section).

Scientific articles. The data obtained over the course of this project has contributed to four manuscripts thus far, which have been prepared for publication in reputable, peer-reviewed journals. The first manuscript, *Assessment of Psychology Competencies in Field Placements: Standardized Vignettes Reduce Rater Bias*, was submitted for review in December 2011. Three other manuscripts are currently under preparation (see the Dissemination section).

There is strong evidence that our dissemination program has been productive. The work of the project is widely known within Australia and New Zealand. Of the seven conference presentations, two were invited. In addition to the six partner universities who collaborated in the project, other tertiary institutions have adopted or have expressed an interest in the assessment tools designed by our project team (e.g., University of Canberra, The Universities of Queensland, The University of Auckland,



and Victoria University). We have also received expressions of interest to collaborate on future research ventures from institutions within Australia and overseas (Newcastle University, Newcastle-upon-Tyne, UK).

In summary, the project has made substantive progress in meeting its commitment to enhance critical awareness among university staff and field supervisors regarding the principles, limitations and possible solutions governing current assessment practices of clinical psychology competencies.

Outcome 2: Designing, evaluating and standardising the clinical psychology practicum competencies rating scale (CΨPRS)

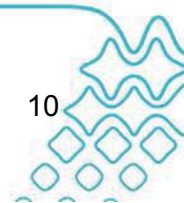
As indicated in the previous section, recent research has questioned the reliability and validity of assessments of student competence determined on the basis of CERF evaluations. However, most previous research is based on small samples and from retrospective studies. Hence, the current project attempted to conduct a large study across participating universities.

Approach and methodology

As a preliminary analysis, end-placement data from consenting supervisor-trainee dyads, collected in the year prior to the commencement of the project (2010), were obtained (Table 2). The data from multiple universities could be combined because a common rating form was used. The results are compelling and demonstrate strong leniency effects among supervisor ratings. Ninety eight percent of students received ratings that fell within Stages 3 and 4. Comparable trends were observed across the five universities that contributed data to the project.

Table 2 – Percentages of end-placement assessments that fell within the four stages of competence, based on supervisors' CΨPRS ratings of students (N=140) in 2010.

Domain	Performance Level			
	Stage 1	Stage 2	Stage 3	Stage 4
1. Counselling Skills	-	.4%	44.5%	55.1%
2. Clinical Assessment	-	2.8%	62.5%	34.7%
3. Case Formulation	-	4.1%	62.0%	33.9%
4. Intervention Skills	-	4.1%	62.0%	33.9%
5. Psychometrics	-	1.9%	64.3%	33.8%
6. Scientist-Practitioner Approach	-	0.3%	54.4%	45.3%
7. Ethical Practice	-	0.2%	55.1%	44.7%
8. Professional Skills	0.1%	1.6%	41.9%	56.3%
9. Response to Supervision	-	0.8%	31.8%	67.5%



Domain	Performance Level			
	Stage 1	Stage 2	Stage 3	Stage 4
Grand Mean	0.0%	1.6%	49.1%	49.3%

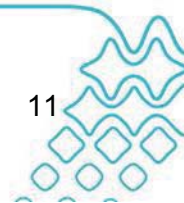
An informed attempt to improve, rather than to reject the rating scale, was warranted for several reasons: (i) an alternative, effective instrument was yet to be designed; (ii) several inadequacies within the rating instrument could be improved; and (iii) considerable supervisor education would be required before a familiar assessment instrument was substituted. Project members and reference-group members attended a full-day workshop and made several modifications to the rating scale. The revised scale, the Clinical Psychology Placement Competencies Rating Scale (CΨPRS), incorporated several improvements, described below.

Conceptualising competency assessment within a developmental framework.

Consistent with international movements towards competency-based approaches to professional training (Kaslow 2004; Leigh et al. 2007; Lichtenberg et al. 2007), a developmental model was adopted for the assessment of competencies. The framework and principles of a developmental approach had specific merits for our case. For instance, because the model suggested that a gradual progression from unskilled to competent performance was ‘normal’ and expected, it also de-stigmatised below-average student performances during early training. It was hoped this would help reduce supervisors’ leniency rating biases.

Shifting from a relative to an absolute reference point. It was possible that rater biases such as halo and leniency effects were propagated because of lack of clarity and precision in definitions of performance levels. An overarching problem was that supervisors were expected to adopt a ‘relative anchor’ and to assess a trainee’s performance in reference to ‘peers at the same developmental level’. Unlike academic staff who become familiar with a range of performance levels by grading a large number of assessments (eg essays), field supervisors train no more than one or two trainees at a time and have no opportunity to develop a ‘normative reference’. Thus, inter-supervisor unreliability could be due to the adoption of different reference points, rather than due to rater bias or error. This lack of a definitive anchor point is made worse with new supervisors who lack previous experience. Therefore, the project adopted as an ‘absolute anchor’, a performance benchmark familiar to field supervisors, namely “the competent performance of a newly qualified clinical psychologist” (see [Appendix A](#) for details). The shift to an absolute reference was expected to reduce uncertainty and yield improved clarity and inter-rater reliability.

Defining developmental stages. Once a developmental model with less variable anchors had been adopted, it became necessary to define progression milestones from unskilled beginner (Stage 1) towards competence (Stage 4). While the recent literature recommends a developmental approach towards the acquisition of competence, there is a distinct lack of guidance on how this might be best achieved. Specifically, there are no recommendations denoting the number of discernible stages during such progress, and whether these stages differ for the various competence domains. A four-stage model was adopted because it replicated the number of categories that supervisors used in previous ratings, and a four-stage model had been adopted in previous research on the acquisition of competence in psychological interventions (Blackburn et al. 2001). Table 3 presents the definitions for the four stages, arrived at by group consensus. It was assumed that the



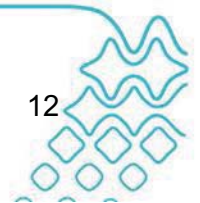
definitions would help improve clarity and specificity, and reduce rater uncertainty and bias.

Table 3 – Definitions of the four developmental stages of competence

Stage	Description
Stage 1 Beginner	Knowledge and skills are at an early stage or yet to be developed. Inadequate knowledge and/or difficulty applying knowledge to practice. Several problems or inadequacies occur during sessions. There may be an absence of key features, inability to prioritise issues or to make appropriate judgments. Little awareness of process issues. On par with trainees commencing training without any practicum experience. Regular and intensive supervision required.
Stage 2	Some basic competencies in assessment and intervention. Manages narrow range of clients with low levels of severity, using structured therapeutic activities. Performance is variable; major problems may occur occasionally; regular supervision required.
Stage 3	Moderate repertoire of basic competencies in both assessment and intervention, leading to management of a wider range of clients. Demonstrates understanding of underlying principles and a moderate ability to generalise these to new cases/situations. Performance can be improved in minor ways; less frequent supervision required.
Stage 4 Competent	Large repertoire of basic to advanced competencies in both assessment and intervention, applied across a range of clients and severity levels. Performance has reached competency levels on a par with a clinical psychologist working in their first job upon qualification.

Measuring progress by a visual analogue scale. There was little within the psychology and educational literature to guide the team in their determination as to whether progression through the developmental stages would be linear or step-wise, and whether the stages would be equidistant from each other. Thus, it is currently unclear whether trainees may be correctly assigned scores that fall between defined stages. The adoption of a visual analogue scale from zero (Stage 1: Unskilled/Beginner) to 10 (Stage 4: Competent) that would allow the supervisor to rate the student anywhere along that continuum seemed appropriate and was adopted.

Skills and progress domains. The number and choice of the domains for the CΨPRS was informed by the international literature and by intensive deliberations within the group before the project commenced. One notable change was made. The team observed that supervisors' ratings sometimes confounded rate of progress within the placement with competence levels. Whereas competence levels represent a metaphorical milestone (station) that the student has already reached, the rate of progress during the placement represents the pace at which the student has travelled to attain the milestone. The CΨPRS separated the two concepts, discriminating between skills and progress domains. Specifically, supervisors were asked to rate the student's pace of progress on a new scale, 'response to



supervision and rate of progress’.

The final version of the CΨPRS adopted for the current project consisted of 69 items across eight skills domains and one progress domain. The CΨPRS was used for end-placement evaluations of students across the participating universities in 2011. In total, 200 end-placement assessments were obtained across five universities; these constitute a valuable and unparalleled data set. Table 4 presents the mid- and end-placement data portraying the distribution of ratings across stages and domains.

Table 4 – Percentages of mid- and end-placement assessments that fell within the four stages of competence, based on supervisors’ CΨPRS ratings.

	Mid-Placement (N = 144)				End-Placement (N = 200)			
	S 1	S 2	S 3	S 4	S 1	S 2	S 3	S 4
1. Counselling Skills	-	4.0	42.7	53.3	-	1.0	18.8	80.2
2. Clinical Assessment	-	7.4	48.3	44.3	-	-	22.7	77.3
3. Case Formulation	0.7	5.9	49.3	44.1	-	1.0	20.5	78.5
4. Intervention Skills	-	15.7	40.4	43.8	-	0.8	31.6	67.7
5. Psychometrics	0.7	6.0	40.0	53.3	-	-	14.8	85.2
6. Scientist-Practitioner Approach	-	3.3	34.0	62.7	-	1.0	12.3	86.7
7. Ethical Practice	-	2.7	22.7	74.7	-	0.5	7.4	92.1
8. Professional Skills	-	2.7	28.7	68.7	-	-	10.3	89.7
9. Response to Supervision	-	2.0	25.3	72.7	-	0.5	8.9	90.6
Grand Mean	0.2	5.5	36.8	57.5	-	0.5	16.4	83.1

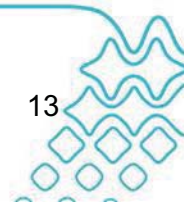
Note. S1 = Stage 1; Values represent per cent (%).

Applications and implementation

The project’s work has received a level of interest, engagement and acclaim that has exceeded our expectations. The problems and dilemmas associated with supervisor ratings of competencies have been an enduring issue that has deeply concerned training staff and supervisors alike. Hence, the project’s progress has been monitored with a great deal of interest. The project’s work has been presented as seven oral presentations at six different conferences, in three international venues (New York, Newcastle-upon-Tyne in the UK and Auckland). Of these, two presentations were by invitation (see details in the Dissemination section).

Results from this project also contribute to the burgeoning body of evidence that CERF assessments by university and field supervisors are affected by systematic leniency and halo biases. The obvious implication is that sole reliance on these ratings is no longer justified.

Although the data from the CΨPRS has not yet been published, there has been keen interest from other psychology schools within Australia and New Zealand. In fact, hard-copy versions of the CΨPRS, or slight modifications of it, are already in



use by universities in Australia (eg Victoria University) and New Zealand (eg The University of Auckland). Other universities (eg University of Canberra) intend to start using the CΨPRS in 2012. Thus, the flow-on effects of the project are ahead of schedule and have exceeded predictions.

Deliverables

- CΨPRS mid-placement form ([Appendix B](#)). This form comprises nine items and is available for use either as a web-based, online instrument or as a hard-copy option. This form is a brief version of the end-placement form and comprises global ratings for each domain, but does not include item-wise ratings within each domain. Because global items are reassessed at end-placement, progress during the placement can be monitored and evaluated.
- CΨPRS end-placement form ([Appendix C](#)). This form comprises five sections. Section A represents supervisor ratings of end-placement competencies and incorporates 60 individual items across all skills domains. Section B comprises qualitative self-appraisal comments by the student. Section C comprises qualitative comments and clarifications about student competencies and or one's ratings by the supervisor. Section D comprises definitions and ratings for the progress domain. Section E includes the final grade and recommendations by the supervisor, including the requirement for specific remedial work, if appropriate. Completion of Sections B, C and E are optional, or may be tailored to suit a specific institution's requirements. The assessment form is available for use either as a web-based, online instrument or as a hard-copy option.
- CΨPRS mid- and end-placement reports. On completion of the online CΨPRS, supervisors and the university clinic director receive an automated email report that profiles the domain-wise evaluation of the student's competence ([Appendix D](#) contains a sample report).

The results from this section of the project have been presented in the following conferences and have been written up for publication in reputed peer-reviewed journals.

- Scientific article 1: see Manuscript 2 under the Dissemination section
- Scientific article 2: see Manuscript 3 under the Dissemination section
- Conference 1: see Presentation 5 under the Dissemination section.

Outcome 3: Design and standardisation of a catalogue of vignettes

The project proposal identified the central goal for this outcome as 'testing an innovative approach to psychology practicum assessment by designing, evaluating and standardising a catalogue of vignettes for assessment of psychology practicum competencies'.

This section covers the methods and procedures used for crafting the vignettes, gathering normative data on them, and constructing the delivery platform for the new assessment procedure. A comparison of the outcomes of the two assessment instruments, the vignette procedure and the CΨPRS will be discussed in the next section.

Approach and methodology

The vignettes were developed in collaboration with representatives from the six participating universities, members of the project's reference group and experts



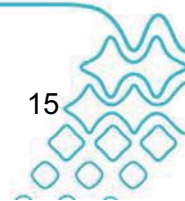
comprising predominantly university psychology clinic directors from Australia or New Zealand. The development of the vignettes involved a complex process.

Version 1 (V1) Vignettes. The matrix of nine domains, including eight skills domains and one progress domain, that had been adopted for the CΨPRS was also used to develop the vignettes. In addition, for the Intervention domain, parallel vignettes for cognitive-behaviour therapies and psychodynamic therapies were generated. Each of the skills domains had four developmental stages to yield a total of 36 cells. Five different categories of progress (unsatisfactory, slow, inconsistent, developing well and excellent) were appropriate for the progress domain; thus, five levels were incorporated within the progress domain. This gave a template of a total of 41 matrix cells across all domains for the generation of vignettes. The university representatives together generated two vignettes per cell. Authors used the extant literature on the topic and the CΨPRS items to determine which key aspects of a competency should be highlighted in the vignettes. This ensured that the vignette did not merely represent an unappealing checklist of competency items. The university representatives were also asked to restrict word length to about 100 words, and to anchor vignettes to each of the four developmental stages of competency attainment.

Version 2 (V2) and Version 3 (V3) Vignettes. The peer review and development of V2 vignettes occurred in one of two ways. Four domains of V1 vignettes were reviewed by expert teams (three to four people per group comprising university representatives or members of the project's reference group) convened for a day-long workshop. The teams had access to all V1 vignettes, tables of adjective-descriptors that authors used for the four different stages and mean accuracy and adequacy scores for each vignette. Adequacy scores were derived from the university representatives' ratings using a five-point Likert scale that assessed the extent to which each vignette correctly identified the stage and discriminated between adjacent stages. The V1 vignettes (blind to authorship) were discussed before incorporating revisions to produce V2 vignettes. V2 vignettes were then assigned to members of other teams, who independently assigned calibration scores for each vignette (a visual analogue scale ranging from 0-10). The feedback was used to produce a final version of the vignettes (see [Appendix E](#)), with the aim of anchoring them within the appropriate band.

- Stage 1 = calibration scores 1 to 2
- Stage 2 = calibration scores 3 to 5
- Stage 3 = calibration scores 6 to 8
- Stage 4 = calibration scores 9 to 10

The remaining five domains were assigned for editing to a subcommittee comprising a panel of four experts recruited specifically for this task. The procedure, summarised in Figure 1, included the following steps: (i) two V1 vignettes per cell were generated by the participating university clinic directors and practicum coordinators; (ii) a subcommittee member with expertise in the domain's content area was assigned lead-authorship for the domain; this member reviewed the V1 vignettes available and produced one revised V2 vignette per cell, using instructions and guidelines similar to those described in the previous paragraph; (iii) V2 vignettes were independently reviewed by two peers who used track-changes to make required revisions; and (iv) a two-member expert panel involving the project's lead investigator and the lead author in Step 2 used the feedback generated to arrive at V3 vignettes.



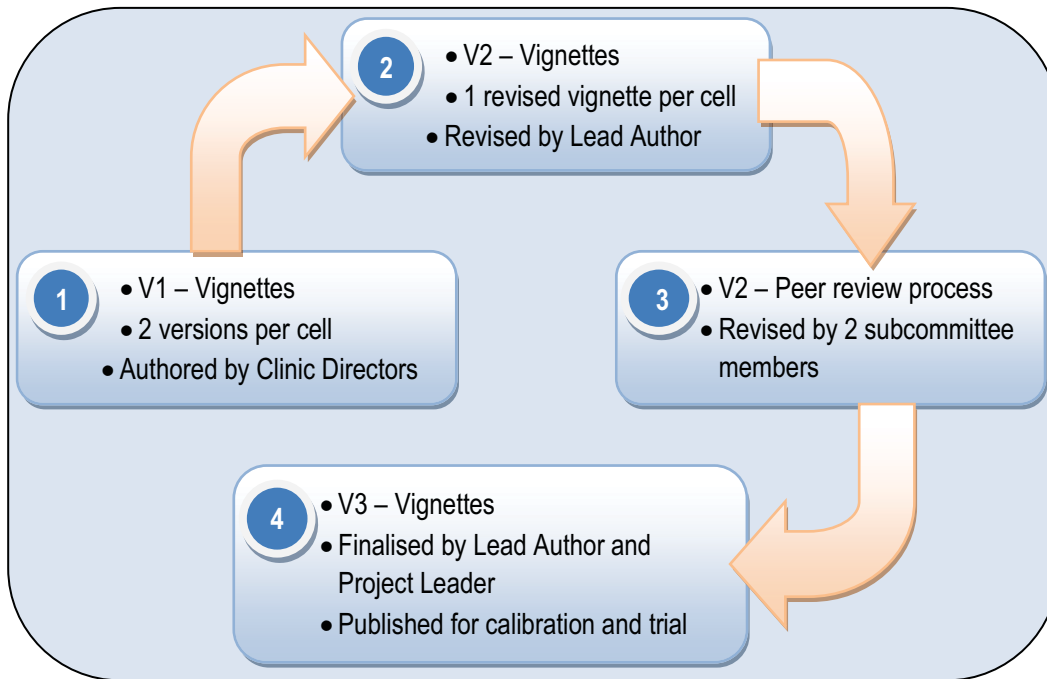
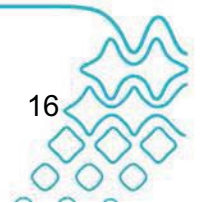


Figure 1 – Procedural steps for vignette standardisation.

Vignette Calibration. V3 vignettes (N=41) were presented in an online survey platform to a group of 20 experts who were invited to participate through email. Vignettes were presented individually in random sequence, and experts were asked to (i) identify the appropriate domain (from a list of nine listed domains); (ii) calibrate the vignette on a visual analogue scale ranging from Beginner (0) to Competent (10); and (iii) rate on a five-point Likert scale how effective the vignette would be for discriminating between stages of development and for overall purposes of evaluating students on practicum performance. Experts completed their task independently and anonymously, and received a \$30 entertainment/book voucher as part-compensation for their time.

Vignette-Matching Procedure (VMP). The VMP involved the presentation of pre-calibrated vignettes to supervisors and invited them to make a judgment as to whether the profile of competencies demonstrated by their student was 'higher than', 'equal to' or 'lower than' the developmental profile captured by the standardised vignette (Appendix E contains examples of vignettes). A computer-based program presented the vignettes in sequence from the first through to the last domain. Within each domain, vignettes were presented in either ascending or descending order. A random program determined whether the series commenced with an ascending (Stage 1 to Stage 4) or descending (Stage 4 to Stage 1) order, with the two orders alternating between domains. The series within the domain terminated when the trainee's competence level was identified (eg when the trainee was identified as possessing competencies higher than vignette 2 but lower than vignette 3). Thus, not all vignettes within a domain were necessarily presented for each student. Supervisors were instructed that the VMP was in the experimental stage, so their scores based on the vignettes would have no bearing on their student's assessment. Following the use of the VMP, supervisors completed a four-item evaluation about the face-validity and utility of the VMP. Following completion of the task, supervisors were offered a \$30 book or movie voucher as compensation for their research participation. Completion of the vignette procedure took, on average,



about 35 minutes per student.

Delivery Platform. A web-based platform for administration of the VMP was used for the current project. The electronic platform was essential to ensure ease of use, time efficiency, consistency and fidelity with regard to administration procedures, and for efficiencies of data storage and analyses. The electronic platform also enabled the order and sequencing of vignettes to be controlled to facilitate presentation in both ascending and descending orders, and to reduce order-driven expectancy and halo effects.

Results and Discussion

Even experts varied in their judgments of where, on a 10-point visual analogue scale, a designed vignette was best anchored. The between-expert variability warranted an additional step in the standardisation procedure: the determination of an empirically derived calibration score for each vignette, based on ratings by a criterion group of experts.

Table 5 presents the data from experts (N=12 or 15, depending on domains) who calibrated the suite of vignettes. The vignettes were required to satisfy each of four criteria to qualify as a standardised vignette:

Table 5 – Mean (SD) calibration scores assigned to vignettes by expert judges using a visual analogue scale^a

Domain	Developmental Stage				
	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
1. Counselling Skills	1.10 (1.19)	3.27 (1.09)	6.29 (<u>1.68</u>)	8.92 (1.49)	
2. Clinical Assessment Skills	1.21 (1.04)	3.35 (1.44)	<u>4.73</u> (1.35)	8.89 (0.97)	
3. Case-Formulation Skills	1.83 (1.37)	3.29 (<u>2.03</u>)	6.12 (1.15)	9.25 (1.03)	
4a. Intervention Skills – Non-CBT	1.30 (1.24)	2.63 (<u>1.64</u>)	7.74 (1.36)	8.95 (0.83)	
4b. Intervention Skills – CBT	1.57 (1.45)	<u>2.53</u> (1.31)	7.63 (1.05)	8.90 (1.01)	
5. Psychometric Skills *	0.83 (0.75)	2.79 (<u>1.92</u>)	6.73 (1.05)	9.23 (0.97)	
6. Scientist-Practitioner Approach *	0.73 (0.82)	2.77 (1.26)	<u>4.68</u> (1.39)	9.43 (1.09)	
7. Ethical Attitude and Behaviour	0.33 (0.59)	<u>2.18</u> (1.37)	6.11 (1.03)	9.28 (1.39)	
8. Professional Skills *	1.90 (<u>1.64</u>)	4.20 (<u>2.23</u>)	7.08 (0.94)	9.45 (0.82)	
9. Response to Supervision and Progress During Placement	1.08 (0.96)	2.21 (1.09)	3.29 (<u>1.71</u>)	7.08 (1.29)	9.46 (1.20)

Note: ^a The visual analogue scale ranged from 0 (Unskilled) to 10 (Competent). The final domain was represented by five vignettes. Underlined Mean and SD values represent vignette scores that violated one or more validation criteria; * These items were based on 12 expert judges, with all other domains based on 15.

- All vignettes met Criterion 1 (95 per cent of raters accurately identified the domain represented by the vignette);
- 38 of 41 vignettes met Criterion 2 (mean calibration scores fell within designated bands);



- 34 of 41 vignettes met Criterion 3 (calibration score standard deviations did not exceed 1.5); and
- 37 of 41 vignettes met Criterion 4 (difference between mean scores of adjacent vignettes within a domain did not exceed 4.0 units).

Eleven of the 41 vignettes (27 per cent) violated one or more criteria and were referred to a subcommittee for further peer review and revision

The capability of our approach to generate normative calibration scores for each vignette, along with a measure of its variability, is an important advantage over a previous study that used vignettes in social work (Bogo et al. 2002). The matrix of calibration scores provides a template of relatively stable anchor points across diverse domains and developmental levels against which competencies can be judged. The profile of calibration scores serves idiographic and normative functions. An idiographic application is the monitoring and tracking of an individual's attainment of competencies over time. The normative function allows the benchmarking of outcomes across cohorts and training programs.

Applications and implementation

- Calibrated and standardised vignettes potentially have major and far-reaching impact and applications.
- Calibration scores provide a framework to monitor an individual student's progress across time.
- Calibration scores provide a framework to benchmark performance of cohorts of trainees across institutions and across time.
- As sets of vignettes could be normed separately for different contexts, disciplines, or even countries in the same way as intelligence tests, calibration scores give the VMP versatility and impact across disciplines.
- Immediate uptake of the VMP will require the completion of the standardisation process. Eleven of 41 vignettes (27 per cent) require recalibration.
- Web-based delivery will greatly improve access to and uptake of the VMP.

Deliverables

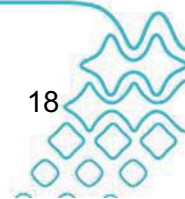
- The main deliverable is a web-based administration of a catalogue of 41 vignettes ([Appendix F](#)). The vignettes capture competencies across eight skills domains (Counselling, Clinical Assessment, Clinical Formulation, Intervention – CBT/ Psychodynamic, Psychometric, Scientist-Practitioner Approach, Ethical Practice and Professional Skills) and one progress domain (Response to Supervision and Progress During Placement). Each skill domain comprises four vignettes. The progress domain comprises five vignettes.

In addition, the results from this section of the project have been presented at several conferences, as listed below.

- Conference presentation 1: see Item 2 under the Dissemination section.
- Conference presentation 2: see Item 3 under the Dissemination section.
- Conference presentation 3: see Item 6 under the Dissemination section.

Outcome 4. Comparison of the two assessment instruments: CΨPRS vs. vignette-matching procedure

Outcome 4 of the project's proposal was 'improving the reliability and validity of



supervisors' end-placement assessments by conducting a landmark, multi-centre study that will systematically evaluate the strengths and limitations of current methods of assessments with the new vignette procedure'.

Approach and methodology

Following the development and the calibration of the vignettes outlined in the previous section, a pilot study was conducted to test the efficacy and viability of the VMP to be used for practicum assessment.

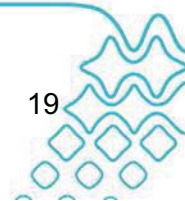
Pilot Study. Twenty field supervisors who had completed end-placement CΨPRS ratings for 20 trainees during a previous month volunteered to participate in the pilot study. For each domain, supervisors were presented the four vignettes concurrently before they were required to pick one the vignettes that best matched the trainee's performance. The competency profile of each student was therefore represented by one of four vignettes across the six domains. Supervisors and students remained anonymous and no attempt was made to match CΨPRS and vignette ratings for the specific students. Supervisors were instructed that vignette ratings would have no bearing on trainee assessments already made. Supervisors were offered a \$30 book or movie voucher as compensation for their time.

Main Study. Following the pilot study, a larger, prospective study was conducted across clinical psychology trainees enrolled in the participating universities. Data from five universities were obtained. Each supervisor who completed the CΨPRS assessment on a trainee was offered the opportunity to complete the Vignette-Matching Procedure (VMP) on the same trainee. This activity allowed us to directly compare matched pairs of practicum ratings derived from the two assessment forms. As each vignette was normed (based on a 0-10 calibration score assigned by the V3 vignette calibration group), a competence score for each student for each of the nine domains could be computed. Students who were matched to vignettes were assigned the calibration score for the vignettes, and students judged as falling in between competency levels portrayed by vignettes (eg higher than Stage 2, but lower than Stage 3) were assigned scores midway between the two vignettes. Supervisors were instructed that the VMP was under development and would have no bearing on actual student assessments.

Upon completion of the two assessment methods, supervisors were provided a four-item evaluation about the face validity and utility of the VMP. Supervisors who completed the VMP were offered the option of claiming a \$30 book or movie voucher as a compensation for their research participation.

Results

Pilot Study. Because the development of vignettes happened in a staggered way, the pilot study yielded data for only six domains (Table 6). As predicted, the VMP yielded distributions that were different from those obtained by the CΨPRS. Although we did not have access to CΨPRS ratings for the same group of students, the VMP results were distinctly different from distributions derived from CΨPRS ratings for a large sample of trainees (N =140) from the same clinical programs during the same year (see Table 2). More than 98 per cent of supervisor ratings on CΨPRS items fell under Stages 3 and 4, and less than 2 per cent of supervisor ratings fell under Stage 2. None of the students received Stage 1 ratings for any of the items. On the contrary, when presented with vignettes, supervisors were willing to match at least some trainees (15-35 per cent, depending on the domain) to lower developmental stages, particularly to Stage 2 (Table 6). Distributions obtained by the VMP were also more consistent with pedagogic considerations, expectations among faculty staff, and predictions from developmental theory. The willingness of



field supervisors to assign lower competency attainments with vignettes also replicates the results of pioneering social-work research by Bogo (2002; 2004).

Table 6 – Percentage of trainees matched to vignettes by field supervisors using the Vignette-Matching Procedure (VMP)

Domain	Developmental Stage				
	N	Stage 1 ^a	Stage 2	Stage 3	Stage 4 ^a
D1. Counselling Skills	20	5%	20%	55%	20%
D2. Clinical-Assessment Skills	20	5%	15%	60%	20%
D3. Case-Formulation Skills	19	-	32%	58%	10%
D4. Intervention Skills	20	-	35%	55%	10%
D7. Ethical Practice	20	-	15%	30%	55%

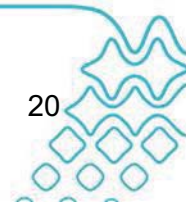
Domain	Developmental Stage					
	Unsat	Slow	Incon	D Well	Excel	
D9. Response to Supervision ^b	20	5%	5%	5%	65%	20%

Note.^a Stage 1 = Beginner; Stage 4 = Competent; ^b This domain is represented by five vignettes and measures response to supervision and progress during placements. D = Domain; Unsat = Unsatisfactory; Slow = Slow Progress; Incon = Inconsistent Progress; D Well = Developing Well; Excel = Excellent Progress.

Main Study. Of the 200 individual CΨPRS forms completed, a total of 80 supervisors completed VMP assessments at end-placement immediately following completion of the CΨPRS. From a total of 80 participants, 73 completed sets were available for analyses (Tables 7 and 8).

Table 7 – Percentage of students (N = 73) rated as falling within the four stages of competence by the CΨPRS and the Vignette-Matching Procedure.

Domain	CΨPRS Items				Vignette-Matching Procedure			
	S 1	S 2	S 3	S 4	S 1	S 2	S 3	S 4
1. Counselling	-	-	28.8	71.2	-	5.6	49.3	45.1
2. Clinical Assessment	-	-	30.4	69.6	-	26.0	15.1	58.9
3. Case Formulation	-	-	33.3	66.7	-	2.8	61.1	36.1
4. Intervention	-	-	28.8	71.2	-	5.6	47.9	46.5
5. Psychometrics	-	1.6	32.8	65.6	6.5	15.2	65.2	13.0
6. Scientist-Practitioner Approach	-	-	17.8	82.2	-	6.5	58.7	34.8
7. Ethical Practice	-	-	17.5	82.5	-	1.4	26.8	71.8
8. Professional	-	0.5	16.9	82.6	-	4.3	34.8	60.9



Domain	CΨPRS Items				Vignette-Matching Procedure			
	S 1	S 2	S 3	S 4	S 1	S 2	S 3	S 4
9. Supervision	-	-	14.9	85.1	-	1.5	43.1	55.4
Grand Mean	-	0.2	24.6	75.2	0.7	7.7	44.7	46.9

Note: * CΨPRS domains Case Formulation and Intervention share the same overall item score; values represent percentages (%).

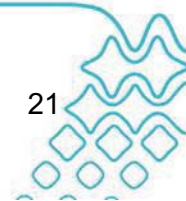
Table 8 – Mean scores for trainees (N = 73) derived from the CΨPRS and the Vignette-Matching Procedure.

Domain	CΨPRS Individual Items	Vignette Matching Procedure
1. Counselling	8.60 (1.10)	7.75 (1.37)
2. Clinical Assessment	8.51 (1.16)	7.47 (1.81)
3. Case Formulation	8.50 (1.10)	7.41 (1.51)
4. Intervention	8.60 (1.10)	7.67 (1.55)
5. Psychometrics	8.45 (1.35)	6.90 (1.86)
6. Scientist-Practitioner Approach	8.92 (0.99)	7.11 (2.00)
7. Ethical Practice	9.03 (1.03)	8.45 (1.41)
8. Professional	8.92 (1.09)	8.17 (1.35)
9. Supervision	9.03 (0.98)	8.17 (1.37)
Grand Mean	8.73 (1.10)	7.68 (1.58)

Note: CΨPRS individual items represent the grand average of all sub-domain items, overall represents the overall items, and VMP represents the converted vignette results based on calibrated scores.

As in the pilot study, compared with the CΨPRS, results from the VMP indicate a broader distribution of competency scores. Specifically, whilst supervisors using the CΨPRS, indicated that most students (75 per cent) had attained competence (matched to Stage 4), a smaller percentage (47 per cent) were matched to the competent vignette on the VMP. Supervisors were also willing to match the competence levels of a small proportion of trainees (M = 7.7 per cent) to Stage 2 using the VMP, but ignored lower stages when using the CΨPRS. These results were also subjected to log linear statistical analyses to determine whether the two instruments yielded different distributions. Compared to the CΨPRS, the VMP yielded a wider distribution and lower scores (higher frequencies in Stage 2 and lower frequencies in Stage 4; $p < .001$). The VMP-CΨPRS differences were more pronounced on some domains than on others ($p < .001$). It is of note that these results occurred even after several changes designed to improve the scale were made to the CΨPRS. Across domains, almost all (99.8 per cent) supervisor ratings on the CΨPRS fell within Stage 3 (around 25 per cent) and Stage 4 (75 per cent) performance bands, with less than 1 per cent of ratings falling within Stage 2 (0.20 per cent) or Stage 1 (0 per cent).

In contrast, on the VMP, across all domains, 7.6 per cent of trainees were judged to



have skills within Stage 2, with this percentage varying across domains from a low of 1.4 per cent of trainees obtaining Stage 2 scores for Ethical Practice and Response to Supervision, to a high of 26 per cent of trainees receiving Stage 2 scores for Clinical Assessment skills. Further, about 6.5 per cent of trainees were judged to be at Stage 1 for psychometric skills. In addition, as might be expected, frequencies across both instruments varied among stages, with larger numbers of trainees placed in Stages 3 and 4; these differences were more pronounced for some domains.

Mean scores for each trainee were also computed for each of the domains to determine if the two methods yielded different results (Table 8). Paired *t*-tests compared means obtained from the two instruments for each domain. The VMP yielded significantly lower means on each of the nine domains ($p < .001$ in each instance), suggesting reduced leniency effects associated with the VMP.

Further, the pattern of between-domain correlations observed for the two assessment methods suggest strong halo biases for the CΨPRS ratings (high correlations across all domains). This is particularly evident from higher correlations between CΨPRS domains than for CΨPRS-VMP correlations for the same domain (Table 9). The results strongly indicate that the VMP significantly reduced the halo bias also.

Table 9 – Pearson correlations based on mean domain ratings on CΨPRS (top right) and the Vignette-Matching Procedure (bottom left)

CΨ/V	CΨ-1	CΨ-2	CΨ-3	CΨ-4	CΨ-5	CΨ-6	CΨ-7	CΨ-8	CΨ-9	
VM-1	.50 [^]	.84 [^]	.89 [^]	.84 [^]	.61 [^]	.66 [^]	.73 [^]	.74 [^]	.70 [^]	CΨ-1
VM-2	.39 ^{**}	.56 [^]	.94 [^]	.94 [^]	.78 [^]	.79 [^]	.78 [^]	.83 [^]	.73 [^]	CΨ-2
VM-3	.41 ^{**}	.52 [^]	.47 [^]	.95 [^]	.73 [^]	.83 [^]	.80 [^]	.81 [^]	.78 [^]	CΨ-3
VM-4	.42 ^{**}	.42 ^{**}	.47 [^]	.40 ^{**}	.77 [^]	.79 [^]	.78 [^]	.79 [^]	.76 [^]	CΨ-4
VM-5	.00	.32	.28	.43 ^{**}	.65 [^]	.78 [^]	.75 [^]	.69 [^]	.70 [^]	CΨ-5
VM-6	.31	.34	.63 [^]	.35	.14	.60 [^]	.81 [^]	.76 [^]	.80 [^]	CΨ-6
VM-7	.50 [^]	.48 [^]	.47 [^]	.60 [^]	.27	.53 ^{**}	.57 [^]	.73 [^]	.87 [^]	CΨ-7
VM-8	.34	.43 ^{**}	.61 [^]	.50 ^{**}	.29	.81 [^]	.63 [^]	.74 [^]	.85 [^]	CΨ-8
VM-9	.58 [^]	.35 [*]	.46 [^]	.45 [^]	.32	.51 ^{**}	.42 ^{**}	.50 ^{**}	.46 [^]	CΨ-9
	VM-1	VM-2	VM-3	VM-4	VM-5	VM-6	VM-7	VM-8	VM-9	CΨ/V

Note: CΨ-1 = CΨPRS Domain 1; VM-1 = Vignette Matching Procedure Domain 1; Shaded cells (diagonal) represent correlations between CΨPRS and the VMP for the same domain.

Finally, field supervisors who trialled the VMP gave it a positive endorsement. Compared to the CΨPRS, the VMP was evaluated by supervisors as having better face-validity, better capturing trainee competencies, not being harder to use, and not being more time consuming (Figure 2).

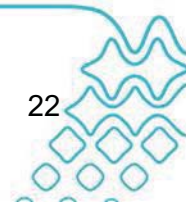
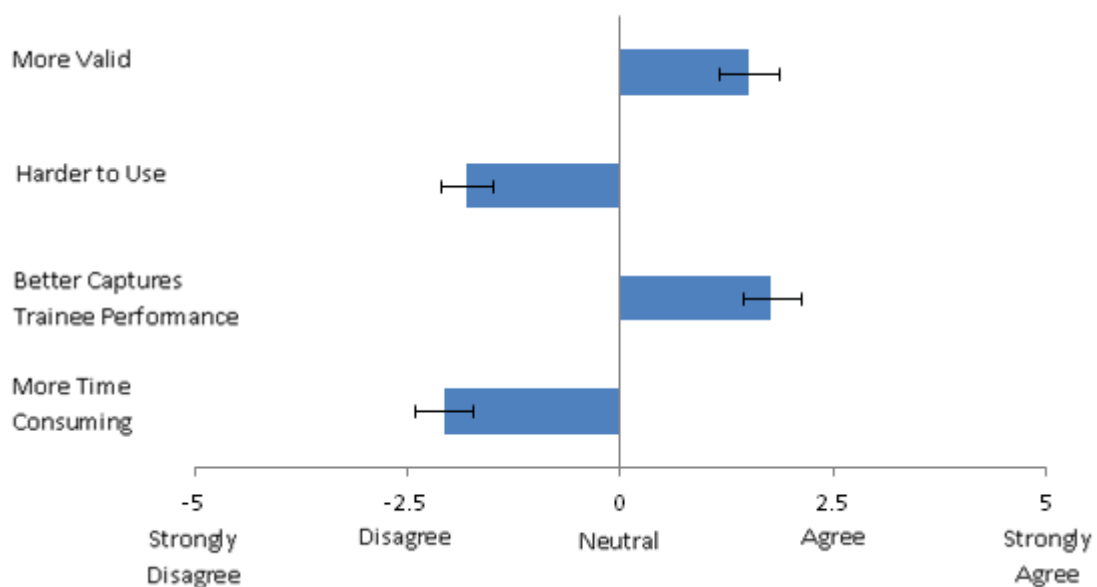
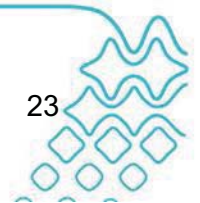


Figure 2 – Field supervisors’ evaluations (means and standard error bars) of the Vignette-Matching Procedure in comparison with the Clinical Psychology Practicum Competencies Rating Scale



Applications and implementation

- Results from both the pilot and main study strongly indicate that the vignette approach to assessment has the potential to reduce leniency and halo biases that seriously affect current ratings systems.
- Of note is that university and field supervisors who used the new instrument compared the instrument favourably with the conventional rating scale. Compared with the CΨPRS, the VMP was endorsed as having better face and ecological validity, was not harder to use, and did not requiring more time to complete.
- A small number of vignettes require re-calibration. Once this occurs, the assessment will be made available to other clinical-psychology institutions within Australia.
- The instrument has excellent uptake potential, and its web-based administration system will make access and uptake more attractive to other institutions.
- Several institutions within Australia and overseas have already expressed interest in using the instrument.
- The VMP also has excellent cross-disciplinary application potential, particularly for health disciplines that offer practicum training and assessment in a similar way to psychology.



Deliverables

The results from this section of the project have been presented in several conferences and have been written up for publication in an internationally reputed, peer-reviewed journal.

- Scientific article 1: see Item 1 under the Dissemination section.
- Conference presentation 1: see Item 4 under the Dissemination section.
- Conference presentation 2: see Item 7 under the Dissemination section.

Factors critical to success

Several factors have contributed to the success achieved by the project.

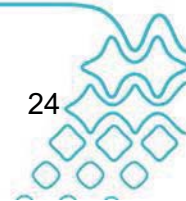
An innovative solution to a critical assessment issue

The use of a standardised vignette to measure competency attainment is an innovative solution to a problem that has dogged practicum assessments in psychology for decades. In all our presentations, the audience (both in psychology and other disciplines) readily engaged with the problem, were attuned to the dilemmas experienced in field placements, were acutely aware of the problem's impact on professional psychology training and were keen to learn of possible solutions. The idea of the vignette is intuitively appealing and stakeholders are able to recognise its potential, both nationally and internationally. To illustrate the project's appeal, a presentation to supervisors at the University of Newcastle, Newcastle-upon-Tyne, UK, resulted in an offer to collaborate on further research on the project, an offer that will be pursued if the project receives continued funding.

Aligning project requirements with customer and stakeholder needs

The project's research outcomes and the stakeholders' assessment needs were not identical. Clinic directors are keen to have a problem-free assessment instrument that is easy to administer and attractive to field supervisors who range in their affinity with information technology. A web-based system of administration for both the CΨPRS and the VMP was essential for efficient and reliable data storage and analyses. A notable achievement was to ensure that the new electronic and online platform introduced was viable and indeed acceptable to participating universities and their many field supervisors. Several customer-friendly options, briefly listed below, had to be designed into the program to accomplish this. These options included steps to ensure privacy and confidentiality of data and the option to maintain independent user-account structures, thereby allowing individual universities to maintain independent and protected access to their own data. These measures minimised the risk of errors, and enhanced efficiencies.

- **Automated Assessment Reports.** Additionally, the web-based system has the capability of generating automated assessment reports. On completion of the online CΨPRS, the supervisor and clinic director concerned receive an automated report via email that simply and efficiently details the trainee's practicum performance. If necessary, the report may then be forwarded to the student. These e-reports are convenient for academic record storage purposes and save supervisors the time and cost of mailing reports to institutions. [Appendix D](#) contains a sample report.
- **Management and analyses of assessment data.** The web-based system also stores, compiles and outputs data in a user-friendly format that allows institutions to chart outcomes across students, cohorts and programmes, and



to evaluate trends and outcomes for quality assurance or research purposes.

- **Module-based assessment formats.** Institutions have specific assessment requirements driven by fairly inflexible university rules and structures. Consequently, arriving at a common assessment format that could satisfy the rigorous assessment policies of all participating universities was a challenging task. The solution was to design the CΨPRS in a modularised format that incorporated a core set of mandatory items and optional sections/items that could be customised as required.

Planning, organisation, and effective dissemination

This one-year project was a multi-centre collaborative endeavour that had an ambitious vision and high aspirations. Collaboration across the six participating universities was always going to be a formidable challenge and was achieved through good planning and organisation, and by cooperation and support from all participating universities. In large part, an effective and efficient dissemination strategy played a key role in achieving success for the project.

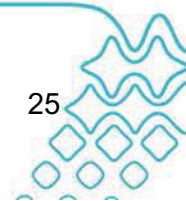
Factors that impeded progress

Delays associated with obtaining approvals from multiple ethics committees

Ethics approval for the use of clinical placement data was initially obtained from the University of Wollongong's Human Research Ethics Committee (HREC). Subsequent applications were submitted to the ethics committees of partner universities. Ethics committees differed in their respective approaches to prior approval by another university's ethics committee, their attention to detail, schedule of meetings, and timely attention to the proposal. Responding to, and fulfilling requirements of, the six ethics committees was a painstaking and sometimes frustrating process, leading to a delayed start and a two-month extension required for project completion.

Additional requirements associated with vignette standardisation

The use of vignettes for assessment is an innovative idea. There was limited assistance from the scientific literature to help determine the methods and protocols to efficiently obtain the best results. In effect, the project had to forge through uncharted territory without established navigation tools. Although the team had anticipated the need for several vignette revisions, we underestimated the complexity, time and resources necessary to craft high-quality vignettes. We also assumed a much higher level of agreement among experts at the vignette calibration phase. Because the results yielded a level of variability that could not be ignored, the project had to incorporate additional steps in the standardisation process: (i) having each vignette rated by a group of experts to produce a normative score (mean and standard deviation) for each vignette; (ii) defining criteria, including value-limits, to differentiate between adequate and inadequate vignettes; (iii) re-crafting vignettes that did not meet these criteria; and (iv) re-establishing normative scores for the revised vignettes. The additional steps have improved the procedure's scientific rigour and enhanced its cross-disciplinary implementation potential, but have also extended completion time. Further, a larger suite of vignettes (41 instead of the planned 28) was required. As a consequence, 11 of the 41 assessment vignettes provided by the project require recalibration. The remaining 30 have met standardisation criteria.

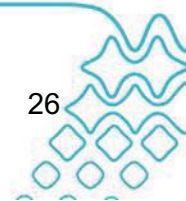


Dissemination

Conferences and workshops

The project's work has been disseminated as multiple presentations at national and international conferences and workshops as indicated below.

1. Gonsalvez, CJ 2010, 'Assessment of clinical psychology competencies in university and field placements: we have a problem!', oral presentation at the Annual Psychology Clinic Directors Conference, Sydney, October 2011.
2. Gonsalvez, CJ, Knight, R, Nicholson Perry, K, Shires, A, Allan, C, Blackman, R, Bushnell, J, Hyde, J & Nasstasia, Y 2011, 'Rating clinical competencies in externships. Can we enhance training outcomes?', invited presentation at the Clinical Psychology Curriculum Conference, Brisbane, 20-21 May 2011.
3. Gonsalvez, CJ, Shires, A, Allan, C, Knight, R, Nicholson Perry, K., Blackman, R, Webster, R, Hyde, J, Bushnell, J & Nasstasia, Y 2011, 'A multi-site study on the assessment of clinical psychology competencies by field supervisors: should vignettes replace rating scales?', paper presented at the Seventh International Interdisciplinary Conference on Clinical Supervision, Adelphi University, New York, 8-10 June 2011.
4. Gonsalvez, CJ, Bushnell, J, Blackmann, R, Deane, F, Bliokas, V, Nasstasia, Y, Nicholson Perry, K, Allan, C, Knight, R, Shires, A & Hyde, J 2011, 'The use of vignettes to capture clinical psychology practicum competencies: vignette standardisation and preliminary results', presented at the ATN Assessment Conference 2011: Meeting the challenges, Curtin University, Perth, 20-21 October 2011.
5. Bushnell, J, Nicholson Perry, K, Blackman, R, Allan, C, Nasstasia, Y, Knight, R, Shires, A, Deane, F, Bliokas, V & Gonsalvez, C 2011, 'Where angels fear to tread? Leniency and the halo effects in practicum-based assessment of student competencies', paper presented at the Australian Technology Network of Universities Conference: Meeting the challenges, Curtin University, Perth, 20-21 October.2011.
6. Gonsalvez, CJ, Knight, R, Nicholson Perry, K, Shires, A, Allan, C, Blackman, R, Bushnell, J, Hyde, J & Nasstasia, Y 2011, 'The vignette project: an innovative method to assess practicum competencies', paper presented at a Clinical Psychology Workshop, Field Supervisors' Assessment of Trainee Competence in Clinical Psychology: Evidence and Practice. Carleton Clinic, Cumbria, National Health Service, University of Newcastle-upon-Tyne, UK, 13 June 2011.
7. Gonsalvez, CJ, Nasstasia, Y, Shires, A, Allan, C, Nicholson Perry, K, Knight, R, Hyde, J, Bushnell, J, Blackman, R, Deane F & Bliokas, V 2011, 'The vignette procedure as an instrument of competency measurement: preliminary results and future directions', invited presentation at the Annual Psychology Clinic Directors Conference, Auckland, New Zealand, 25-26 November 2011.



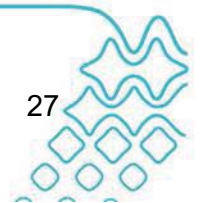
Scientific articles

In addition, four scientific articles have been or will shortly be submitted to reputed, peer-reviewed journals. These manuscripts, available from Craig Gonsalvez (craig@uow.edu.au), include:

1. Gonsalvez, CJ, Bushnell, J, Blackmann, R, Deane, F, Bliokas, V, Nasstasia, Y, Nicholson Perry, K, Allan, C, Knight, R & Shires, A, 'Assessment of psychology competencies in field placements: standardized vignettes reduce rater bias', manuscript submitted to *Teaching and Education in Professional Practice*.
2. Bushnell, J & Gonsalvez, CJ et al. 'Where angels fear to tread? Leniency and the halo effects in practicum-based assessment of student competencies', manuscript to be submitted shortly to *Australian Psychologist*.
3. Deane, F, Gonsalvez, CJ & Bushnell, J et al. 'The Clinical Psychology Practicum Competencies Rating Scale: internal structure and reliability', manuscript in preparation for *Professional Psychology: Research and Practice*.
4. Nicholson Perry, K, Gonsalvez, CJ & Shires, A, 'Assessing competencies in clinical psychology training: past, present and future', manuscript in preparation.

Web-based deliverables

5. The project homepage, which hosts links to all participating institutions' versions of the CΨPRS, is available at:
<<http://www.uow.edu.au/health/iimh/vignette-matching/index.html>>
6. The CΨPRS mid-placement assessment instrument is available for trial by universities within and outside Australia at:
<https://uowpsych.us.qualtrics.com/SE/?SID=SV_2fcZT2Cyept6CWM>
7. The CΨPRS end-placement assessment instrument is available for trial by universities within and outside Australia at:
<https://uowpsych.us.qualtrics.com/SE/?SID=SV_cMheOezW9tIXbzm>
8. The Vignette-Matching Procedure instrument is available for trial by universities within and outside Australia at:
<https://uowpsych.us.qualtrics.com/SE/?SID=SV_0TXBDjDryNVueFK&SSID=SS_aeYIxWhi7x9MW1e>



Linkages

The project's work has led to the establishment of several valuable linkages within psychology and with other disciplines.

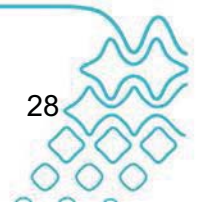
Linkages within psychology

A close relationship between the project's group and the Executive of the Australia and New Zealand Psychology Clinic Directors has been established. Presentations about the project's work were made in 2010 and an invited presentation was made in 2011. The conference organising committee has expressed interest in an updated presentation in 2012. This group has much influence on practicum training and assessment in clinical psychology within Australia. From a strategic perspective, a close linkage with this core group is vital to consolidate and extend implementation of the project's contributions to assessment.

The project team also established good collaborative links with another ALTC-funded project in psychology, 'Taking clinical psychology postgraduate training into the next decade: aligning competencies to the curriculum'. In fact, Professor Pachana, the lead investigator was also a member of our Reference Group, and the current project contributed a presentation to an ALTC event organised by this group (see item 2 under Conferences within the Dissemination section). We continue to maintain linkages with this group to facilitate future interactions and collaborations. Several other linkages have also been established with specific institutions which are currently using the assessment tools we have designed or have expressed interest in future collaborative research (eg University of Canberra, The University of Auckland, Victoria University, The University of Queensland, Newcastle University, Newcastle-upon-Tyne in UK).

Interdisciplinary linkages

The assessment issues that the project addresses apply to non-psychology disciplines, especially health-related disciplines. Professor Bushnell, who is co-leader of the project and Associate Dean, Faculty of Medicine, facilitates psychology-medicine networking and, if appropriate, will lead flow-on implementation strategies for medicine at the next stage of the project. We have also presented our work at the Seventh International Interdisciplinary Conference on Clinical Supervision (New York) and have established a linkage with Professor Bogo at the University of Toronto, who heads an active research group committed to improving practicum assessment outcomes in social work. This linkage may help inform and guide implementation of the vignette procedure to non-psychology disciplines in future projects.



Evaluation

The funding for the project was below the budget threshold for a formal evaluation, so an independent evaluation was not commissioned. However, a number of monitoring and evaluation strategies were employed to ensure adequate progress was maintained through the course of the project.

Planning and evaluation subcommittee

The occurrence of several unanticipated problems early in the project's tenure prompted the setting up of a planning and evaluation subcommittee. The subcommittee served evaluative and trouble-shooting functions that complemented the work conducted by the larger group that included representatives from all participating universities. The subcommittee was smaller, more agile, had input from two independent experts, and provided several effective solutions to problems that arose.

Evaluation of vignettes by stakeholders

Field supervisors who were recruited to trial the newly designed suite of vignettes were also recruited to evaluate the assessment potential of the new procedure. Compared to the CΨPRS, the VMP was rated by supervisors as having better face-validity, better capturing trainee competencies, not being harder to use, and not being more time consuming. See Figure 2 for more details of this evaluation.

Evaluation based on proposal outcomes

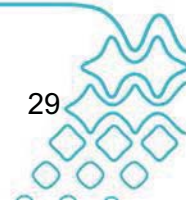
Overall, there is strong evidence that the project has delivered on all of the four outcomes promised by the initial proposal.

Outcome 1

Goals for this outcome have been fully met and exceeded. The project has attracted the attention and active engagement of the university clinic directors through effective and sustained dissemination strategies, and has gained respect and recognition within Australia and overseas. The project's work has been presented in four oral presentations at three conferences within Australia, in two presentations in international conferences and in one international workshop. Two of these presentations have been invited papers.

Outcome 2

Goals for this outcome have been fully met and exceeded. In addition to standardising the CΨPRS, we have generated a user-friendly, online administration of the instrument that is fully operational and is currently being used by the five partner universities within Australia. We have designed the web-based delivery system with functionalities that make the instrument attractive to other universities. Although the project is just wrapping up, several universities have already commenced using hard-copy versions of the CΨPRS for their practicum assessment, and others are considering uptake in 2012. Thus, we are ahead of our targets in terms of implementation and uptake schedules. The project has generated a wealth of valuable data, including 144 mid- and 200 end-placement CΨPRS evaluations. The achieved data numbers exceed proposal target numbers and enable appropriate statistical analyses. Two scientific articles reporting these results are already underway, and will be submitted to peer-reviewed journals shortly.

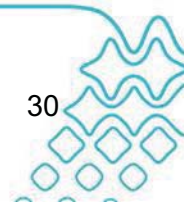


Outcome 3

Goals associated with this outcome have not been fully met, but have been met at a level of 75 per cent or higher. The vignette-standardisation process was more complex than originally anticipated, requiring additional steps. The additional steps have given the vignette procedure additional scientific rigour, and have increased its potential for cross-disciplinary implementation, but have also delayed the completion of the suite of vignettes. A larger suite of vignettes (41 instead of the proposed 28) has been designed, but only 73 per cent (30 of 41) of the vignettes have met stringent standardisation criteria. The required revisions of the remaining vignettes have been completed, but final validation for these vignettes is pending.

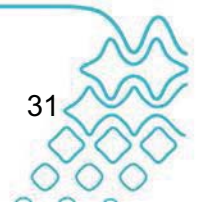
Outcome 4

Goals associated with this outcome have been fully met. We currently have both pilot and main-study data comparing the CΨPRS with the vignette method, demonstrating better assessment outcomes with the new vignette procedure. A scientific article has been written up and submitted to a reputed, international, peer-reviewed journal.

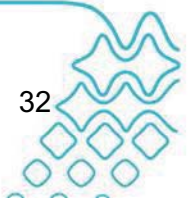


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Appendices



Appendix A – Domain Descriptors

Domain Name	Descriptor
1. Relational Skills	Includes ability for empathic understanding, application of basic counselling techniques, and collaborative goal formulation with clients.
2. Clinical-Assessment Skills	Includes ability to perform adequate assessments in a time efficient and in a personally/socio-culturally sensitive manner. Ability to demonstrate appropriate diagnostic skills, prioritise issues and assess risk.
3. Case-Formulation Skills	Ability to appropriately conceptualise and formulate cases.
4. Intervention Skills	Ability to generate realistic treatment plans and monitor treatment progress and outcomes. Knowledge and skills required to conduct a range of empirically supported treatment interventions.
5. Ethical Practice	Knowledge of and commitment to ethical/professional codes, standards and guidelines, and recognition of applicable circumstances. Maintains appropriate and respectful boundaries and seeks consultation on ethical issues.
6. Professional Skills	Effective organisation and time management for client care and management. Clear and professional expressive skills, professional dress and demeanour. Good interactional skills with colleagues and other professionals.
7. Scientist-Practitioner Approach	Knowledge of theoretical and research evidence related to diagnosis, assessment and intervention. Respect for scientific methods and empirical evidence and commitment to their application to clinical practice
8. Psychometric Skills	Ability to apply knowledge to correctly select, administer, score and interpret relevant psychometric tests. Good reporting skills. Knowledge of psychometric issues and testing theory.
9. Response to Supervision	Good preparation and collaboration within supervision, openness to and effective use of feedback. Ability to self-reflect and self-evaluate accurately



Appendix B – Mid Placement Report

The University of _____ – Clinical Psychology Practicum Competencies Rating Scale Mid Placement Review Form (CΨPRS-MP)

Name of Clinical Trainee:.....

Trainee’s Email Address:.....

Primary Supervisor:.....

Additional Supervisors:.....

Date of Placement: From To

Placement hours completed as part of the clinical degree before this placement began (mention approximate number, e.g., 250/500 hours):

Placement Agency:

Client Population/s (circle):

Older Adult Adult Adolescent Child and Family Other.....

Setting (circle):

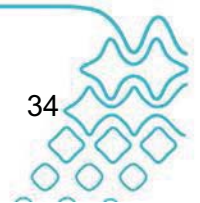
University Clinic NSW health Corrective Services DOCS Private Practice Other.....

Placement Type/s (Circle):

Inpatient Hospital Outpatient Community Health Mental Health Other.....

Therapeutic Approach/es (circle) :

CBT DBT ACT IPT Psychodynamic Schema Family Therapy Other..... N/A



SECTION A

The set of clinical competencies is divided into 9 broad domains as indicated in the table below.

For each domain, a developmental approach towards attainment of competence is adopted, and four stages from Beginner (Stage 1) to Competent (Stage 4) are identified. Your rating reflects your judgment of the stage that best matches the trainee’s **current** performance level (not at placement commencement or a month ago).

DO NOT rate trainees in comparison with their peers, but in reference to a notional absolute standard of competent professional practice (Stage 4).

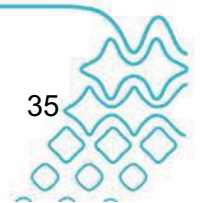
Competence at Stage 4 is defined as comprising capabilities and skills on par with a clinical psychologist working in their first job following completion of their Masters degree.

It is anticipated that ratings across placements during Clinical Masters Years 1 & 2 should reflect progression towards competency and that most trainees will attain Stage 4 at course completion. Performance levels during earlier placements are likely to match Stages 1 and 2 and, as training progresses, move towards Stages 3 and 4.

An important role of supervisors is to be gate-keepers of the profession. So you are strongly encouraged to mention any concerns you might have about the trainee’s suitability for clinical practice, slow progress, or specific needs. If you are uncertain about an issue, write it down and indicate that you are uncertain and require additional discussion/clarification about the issue.

Stages	Description of Stages
Stage 1. Beginner	Knowledge and skills are at an early stage or yet to be developed. Inadequate knowledge and/or difficulty applying knowledge to practice. Several problems or inadequacies occur during sessions. There may be an absence of key features, inability to prioritise issues or to make appropriate judgements. Little awareness of process issues. On par with trainees commencing training without any practicum experience. Regular and intensive supervision required.
Stage 2.	Some basic competencies in assessment and intervention, manages narrow range of clients with low levels of severity, using structured therapeutic activities. Performance is variable; major problems may occur occasionally; regular supervision required.
Stage 3.	Moderate repertoire of basic competencies in both assessment and intervention leading to management of a wider range of clients. Demonstrates understanding of underlying principles and a moderate ability to generalise these to new cases/situations. Performance can be improved in minor ways; less frequent supervision required.
Stage 4. Competent	Large repertoire of basic to advanced competencies in both assessment and intervention, applied across range of clients and severity levels. Performance has reached competency levels on a par with a clinical psychologist working in their first job upon qualification.

You must complete this section. To record your rating, place a vertical line on the scale or tick N/A for not applicable/observed (if this box is available).



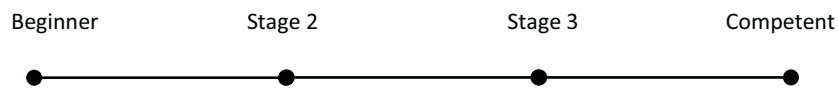
1. Relational skills.

Includes ability for empathic understanding, application of basic counselling techniques, and collaborative goal formulation with clients.



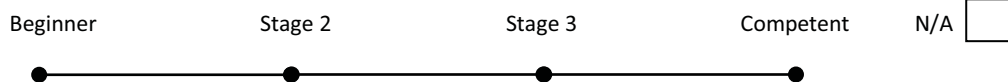
2. Clinical assessment skills.

Includes ability to perform adequate assessments in a time efficient and in a personally/socio-culturally sensitive manner. Ability to demonstrate appropriate diagnostic skills, prioritise issues, and assess risk.



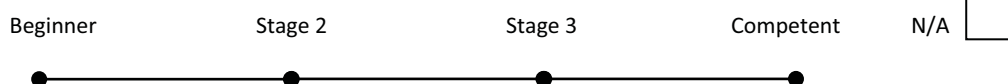
3. Formulation and Intervention skills.

Ability to appropriately conceptualise and formulate cases, generate realistic treatment plans and monitor treatment progress and outcomes. Knowledge and skills required to conduct a range of empirically supported treatment interventions.



4. Psychometric Skills.

Ability to apply knowledge to correctly select, administer, score and interpret relevant psychometric tests. Good reporting skills. Knowledge of psychometric issues and testing theory.



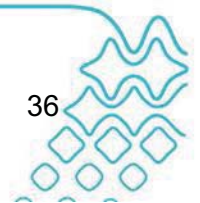
5. Scientist practitioner approach.

Knowledge of theoretical and research evidence related to diagnosis, assessment and intervention. Respect for scientific methods and empirical evidence and commitment to their application to clinical practice



6. Personal attributes.

Cognitive (e.g., problem solving, logical analysis), affective (e.g., tolerance of affect/ambiguity), motivational (values), and reflective skills conducive to professional psychology.



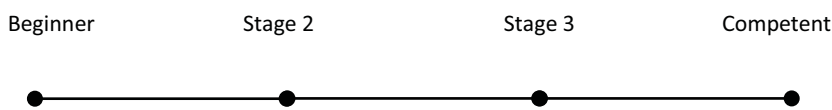
7. Ethical practice.

Knowledge of and commitment to ethical/professional codes, standards and guidelines, and recognition of applicable circumstances. Maintains appropriate and respectful boundaries and seeks consultation on ethical issues.



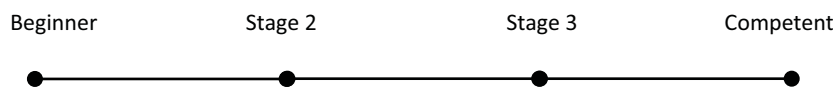
8. Professional skills.

Effective organisation and time management for client care and management. Clear and professional expressive skills, professional dress and demeanour. Good interactional skills with colleagues and other professionals.



9. Response to Supervision.

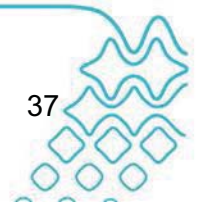
Good preparation and collaboration within supervision, openness to and effective use of feedback. Ability to self-reflect and self-evaluate accurately



SECTION B

SELF APPRAISAL BY THE INTERN

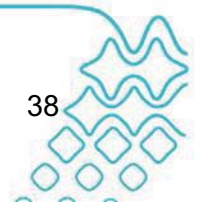
Please give your own views about your learning on this placement. Please identify the areas where you feel you have demonstrated significant development, the areas that you feel you have been challenged, and the areas that you feel it is important for you to continue to work on and develop.



Section C

SUPERVISOR FREE COMMENTS

Supervisors may mention goals, rate of progress made during placement. If comment refers specifically to one or more of the 9 domains rated above, please mention domain name or number.



SECTION D

PLACEMENT PROGRESS

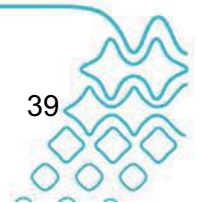
Whereas in the previous section, trainees were assessed based on a notional absolute standard of competence, items in this section must be rated relative to performance of peers and with respect to their current stage of development. Thus “unsatisfactory, slow, or excellent progress” may be assigned to trainees at any stage of development.

Please rate the trainee’s progress thus far. Ensure your rating is not influenced by the reasons that may have contributed to the trainee’s progress/lack of progress. If progress is below levels expected, please comment on factors in the free-text section below.,(e.g.; attitudinal barriers, personal issues including illness).

Unsatisfactory Progress	Progress is considerably slower than the pace expected at this stage of training. Consequently, little or no change has been observed in the trainee’s capabilities. Major deficits in one or more areas that are of serious concern.
Slow progress	Some progress has been made, but progress has been uniformly slow across most domains, or has been achieved following above-average investments of staff resources. Rate of progress is below the standard expected at this stage of training.
Inconsistent Progress	Progress has been inconsistent or patchy across time and/or domains, with satisfactory progress achieved some of the time/in some domains but not all the time/across all domains.
Developing Well	Consistent and good progress has been achieved. The rate of progress matches expectations for trainees at this stage of training.
Excellent progress	The trainee has made accelerated progress during the placement, much above the rate expected at this stage of training.
Comment:	

Supervisor’s Signature: **Date:**

Clinical Trainee’s Signature: **Date:**



Appendix C – End Placement Report

The University of _____ – Clinical Psychology Practicum Competencies Rating Scale
End Placement Review Form (CΨPRS)

Name of Clinical Trainee:.....

Trainee’s Email Address:.....

Primary Supervisor:.....

Additional Supervisors:.....

Date of Placement: From To

Placement hours completed as part of the clinical degree before this placement began (mention approximate number, e.g., 250/500 hours):

Placement Agency:

Client Population/s (circle):

Older Adult Adult Adolescent Child and Family Other.....

Setting (circle):

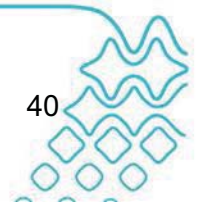
University Clinic NSW health Corrective Services DOCS Private Practice Other.....

Placement Type/s (Circle):

Inpatient Hospital Outpatient Community Health Mental Health Other.....

Therapeutic Approach/es (circle) :

CBT DBT ACT IPT Psychodynamic Schema Family Therapy Other..... N/A



SECTION A

The set of clinical competencies is divided into 9 broad domains as indicated in the table below.

For each domain, a developmental approach towards attainment of competence is adopted, and four stages from Beginner (Stage 1) to Competent (Stage 4) are identified. Your rating reflects your judgment of the stage that best matches the trainee’s **current** performance level (not at placement commencement or a month ago).

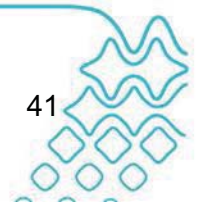
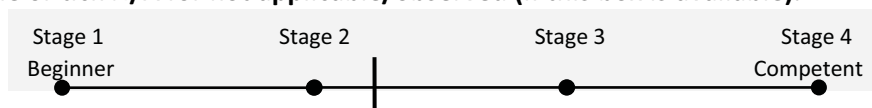
DO NOT rate trainees in comparison with their peers, but in reference to a notional absolute standard of competent professional practice (Stage 4). Competence at Stage 4 is defined as comprising capabilities and skills on par with a clinical psychologist working in their first job following completion of their Masters degree.

It is anticipated that ratings across placements during Clinical Masters Years 1 & 2 should reflect progression towards competency and that most trainees will attain Stage 4 at course completion. Performance levels during earlier placements are likely to match Stages 1 and 2 and, as training progresses, move towards Stages 3 and 4.

An important role of supervisors is to be gate-keepers of the profession. So you are strongly encouraged to mention any concerns you might have about the trainee’s suitability for clinical practice, slow progress, or specific needs. If you are uncertain about an issue, write it down and indicate that you are uncertain and require additional discussion/clarification about the issue.

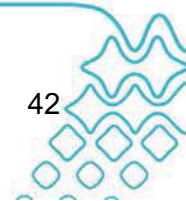
Stages	Description of Stages
Stage 1. Beginner	Knowledge and skills are at an early stage or yet to be developed. Inadequate knowledge and/or difficulty applying knowledge to practice. Several problems or inadequacies occur during sessions. There may be an absence of key features, inability to prioritise issues or to make appropriate judgements. Little awareness of process issues. On par with trainees commencing training without any practicum experience. Regular and intensive supervision required.
Stage 2.	Some basic competencies in assessment and intervention, manages narrow range of clients with low levels of severity, using structured therapeutic activities. Performance is variable; major problems may occur occasionally; regular supervision required.
Stage 3.	Moderate repertoire of basic competencies in both assessment and intervention leading to management of a wider range of clients. Demonstrates understanding of underlying principles and a moderate ability to generalise these to new cases/situations. Performance can be improved in minor ways; less frequent supervision required.
Stage 4. Competent	Large repertoire of basic to advanced competencies in both assessment and intervention, applied across range of clients and severity levels. Performance has reached competency levels on a par with a clinical psychologist working in their first job upon qualification.

You must complete the following section. To record your rating, place a vertical line on the scale or tick N/A for not applicable/observed (if this box is available).

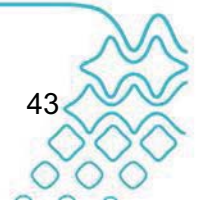


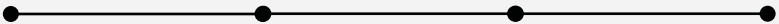






1. Relational skills Includes ability for empathic understanding, application of basic counselling techniques, and collaborative goal formulation with clients.	Overall Rating			
	Stage 1 Beginner	Stage 2	Stage 3	Stage 4 Competent
	●—————●—————●—————●			
a) Ability to form and communicate an empathic understanding to clients, carers, and significant others.	●—————●—————●—————●			
b) Ability to apply basic counselling techniques appropriately including clarification, paraphrase and summarisation responses.	●—————●—————●—————●			
c) Ability to use active and responsive listening skills.	●—————●—————●—————●			
d) Ability to formulate client goals in a collaborative manner.	●—————●—————●—————●			
Comments (optional):				





2. Clinical Assessment Skills Includes ability to perform adequate assessments in a time efficient and in a personally/socio-culturally sensitive manner. Ability to demonstrate appropriate diagnostic skills, prioritise issues, and assess risk.	Overall Rating			
	Stage 1 Beginner	Stage 2	Stage 3	Stage 4 Competent
	●—————●—————●—————●			
a) Efficiency in conducting an adequate assessment.	●—————●—————●—————●			
b) Ability to apply appropriate breadth of questioning to cover important issues including a mental state examination.	●—————●—————●—————●			
c) Ability to apply appropriate depth of questioning to ensure adequate understanding of key issues.	●—————●—————●—————●			
d) Ability to use a hypothesis testing framework effectively.	●—————●—————●—————●			
e) Ability and skill to make correct diagnoses and differential diagnoses.	●—————●—————●—————●			
f) Ability to undertake assessments in a socio-culturally sensitive manner.	●—————●—————●—————●			
Comments (optional):				

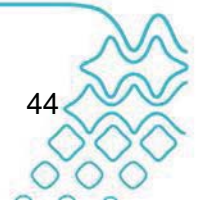


3. Formulation and Intervention Skills Ability to appropriately conceptualise and formulate cases, generate realistic treatment plans and monitor treatment progress and outcomes. Knowledge and skills required to conduct a range of empirically supported treatment interventions.	Overall Rating <div style="text-align: right;">N/A <input type="checkbox"/></div> <div style="display: flex; justify-content: space-between; font-size: small;"> Stage 1 Beginner Stage 2 Stage 3 Stage 4 Competent </div>
a) Ability to conceptualise and formulate cases appropriately.	
b) Ability to integrate assessment information into realistic treatment plans.	
c) Ability to implement a range of interventions relevant to the placement.	
d) Knowledge of empirically supported treatment methods, e.g. CBT, IPT, MI.	
e) Skills to conduct empirically supported treatment techniques, e.g. CBT, IPT, MI.	
f) Knowledge of strengths and limitations of applied therapeutic approaches.	
g) Demonstrates flexibility and responsiveness in the application of treatments and/or in the implementation of manualised programs.	
h) Ability to integrate cultural knowledge into formulation and treatment.	
i) Skills to deal with common difficulties in therapy.	
j) Ability to undertake assessment of treatment progress and outcome.	
Comments (optional): 	

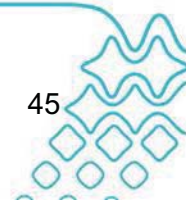





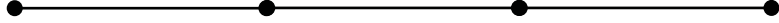

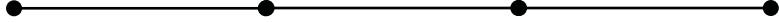
4. Psychometric Skills Ability to apply knowledge to correctly select, administer, score and interpret relevant psychometric tests. Good reporting skills. Knowledge of psychometric issues and testing theory.	Overall Rating <div style="text-align: right;">N/A <input type="checkbox"/></div> <div style="display: flex; justify-content: space-between;"> Stage 1 Beginner Stage 2 Stage 3 Stage 4 Competent </div> 
a) Ability to apply theoretical knowledge to select appropriate tests.	
b) Ability to correctly administer common/core tests.	
c) Ability to score tests accurately.	
d) Ability to interpret results and formulate conclusions.	
e) Knowledge of psychometric issues, testing theory, and bases of assessment methods.	
f) Ability to integrate information into a psychometric report.	
Comments (optional): 	








5. Scientist Practitioner Approach Knowledge of theoretical and research evidence related to diagnosis, assessment and intervention. Respect for scientific methods and empirical evidence and commitment to their application to clinical practice	Overall Rating <div style="display: flex; justify-content: space-between;"> Stage 1 Beginner Stage 2 Stage 3 Stage 4 Competent </div> 
a) Commitment to applying theoretical and research knowledge relevant to the practice of psychology within the clinical setting.	
b) Knowledge of theoretical and research evidence related to diagnosis, assessment and intervention.	
c) Respect for and use of the scientific method in clinical work.	
Comments (optional): 	

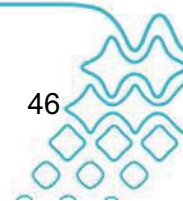


6. Personal Capacities Cognitive (e.g., problem solving, logical analysis), affective (e.g., tolerance of affect/ambiguity), motivational (values), and reflective skills conducive to professional psychology.	Overall Rating			
	Stage 1 Beginner	Stage 2	Stage 3	Stage 4 Competent
	●	●	●	●
a) Cognitive skills: problem-solving ability, critical thinking, organised reasoning, intellectual curiosity and flexibility.	●	●	●	●
b) Affective skills: affect tolerance; tolerance/understanding of interpersonal conflict; tolerance of ambiguity and uncertainty.	●	●	●	●
c) Personality/Attitudes: desire to help others; openness to new ideas; honesty/integrity/valuing of ethical behaviour; personal courage.	●	●	●	●
d) Demonstrates accurate self appraisal and understanding.	●	●	●	●
e) Reflective skills: ability to examine and consider one's own motives, attitudes, behaviours and one's effect on others.	●	●	●	●
f) Willingness to acknowledge one's inadequacies and a commitment to work towards positive change.	●	●	●	●
g) Ability to identify personal distress, particularly as it relates to clinical work.	●	●	●	●
h) Ability to work effectively with diverse others in assessment, treatment and consultation.	●	●	●	●
i) Respect for others' including cross-cultural values and perspectives.	●	●	●	●
j) Demonstrates progress in developing an integrated sense of self as a professional psychologist	●	●	●	●
Comments (optional):				



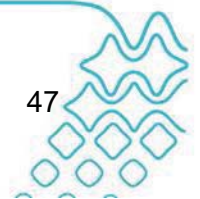
7. Ethical Practice Knowledge of and commitment to ethical/professional codes, standards and guidelines, and recognition of applicable circumstances. Maintains appropriate and respectful boundaries and seeks consultation on ethical issues.	Overall Rating Stage 1 Beginner Stage 2 Stage 3 Stage 4 Competent 
a) Knowledge of ethical/professional codes, standards and guidelines.	
b) Recognition and analysis of ethical and legal issues across the range of professional activities.	
c) Seeks appropriate information and consultation when faced with ethical issues.	
d) Commitment to and compliance with ethical practice.	
e) Understands and maintains appropriate boundaries and displays respectful behaviour towards clients, staff and peers.	
Comments (optional): 	

8. Professional Skills Effective organisation and time management for client care and management. Clear and professional expressive skills, professional dress and demeanour. Good interactional skills with colleagues and other professionals.	Overall Rating Stage 1 Beginner Stage 2 Stage 3 Stage 4 
a) Ability to effectively structure and manage therapy time (e.g. prioritise, set limits, finish sessions on time).	
b) Completion of professional tasks (e.g. evaluations, notes, reports, contacting clients, arriving promptly at meetings and appointments) in time.	
c) Demonstrates an organised, disciplined approach to writing and maintaining notes and records.	
d) Ability to organise and clearly present case material, and professional reports for a range of consumers.	
e) Expressive skills: ability to communicate one's ideas, feelings and information in verbal, non-verbal and written forms for a range of purposes.	
f) Undertakes duties such as intake, telephone duty etc. and assists where required with professional tasks.	



g) Conducts self professionally in dress and demeanour.	●──────────●──────────●──────────●
h) Demonstrates effective presentation skills e.g. case presentation, group presentation.	●──────────●──────────●──────────●
i) Ability to work collaboratively with colleagues across a range of disciplines.	●──────────●──────────●──────────●
Comments (optional):	

9. Response to Supervision Good preparation and collaboration within supervision, openness to and effective use of feedback. Ability to self-reflect and self-evaluate accurately	Overall Rating Stage 1 Stage 2 Stage 3 Stage 4 Beginner
a) Ability to work collaboratively with the supervisor.	●──────────●──────────●──────────●
b) Demonstrates adequate preparation for supervision.	●──────────●──────────●──────────●
c) Ability/willingness to accept supervisory input, including direction.	●──────────●──────────●──────────●
d) Ability to follow through on recommendations.	●──────────●──────────●──────────●
e) Ability to appropriately balance autonomy and dependency needs.	●──────────●──────────●──────────●
f) Ability to self-reflect and self-evaluate accurately regarding clinical skills and use of supervision.	●──────────●──────────●──────────●
g) Ability to use good judgment as to when supervisory input is necessary.	●──────────●──────────●──────────●
Comments (optional):	



SECTION B

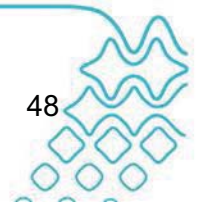
SELF APPRAISAL BY THE INTERN

Please give your own views about your learning on this placement. Please identify the areas where you feel you have demonstrated significant development, the areas that you feel you have been challenged, and the areas that you feel it is important for you to continue to work on and develop.

SECTION C

SUPERVISOR FREE COMMENTS

Supervisors may mention goals, rate of progress made during placement. If comment refers specifically to one or more of the 9 domains rated above, please mention domain name.



SECTION D

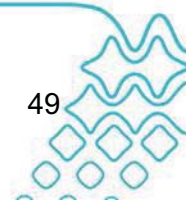
PLACEMENT PROGRESS

Whereas in the previous section, trainees were assessed based on a notional absolute standard of competence, items in this section must be rated relative to performance of peers and with respect to their current stage of development. Thus “unsatisfactory, slow, or excellent progress” may be assigned to trainees at any stage of development.

Please rate the trainee’s progress thus far. Ensure your rating is not influenced by the reasons that may have contributed to the trainee’s progress/lack of progress. If progress is below levels expected, please comment on factors in the free-text section below. (e.g., attitudinal barriers, personal issues including illness).

Please circle the appropriate box.

Unsatisfactory Progress	Progress is considerably slower than the pace expected at this stage of training. Consequently, little or no change has been observed in the trainee’s capabilities. Major deficits in one or more areas that are of serious concern.
Slow progress	Some progress has been made, but progress has been uniformly slow across most domains, or has been achieved following above-average investments of staff resources. Rate of progress is below the standard expected at this stage of training.
Inconsistent Progress	Progress has been inconsistent or patchy across time and/or domains, with satisfactory progress achieved some of the time/in some domains but not all the time/across all domains.
Developing Well	Consistent and good progress has been achieved. The rate of progress matches expectations for trainees at this stage of training.
Excellent progress	The trainee has made accelerated progress during the placement, much above the rate expected at this stage of training.
Comments:	



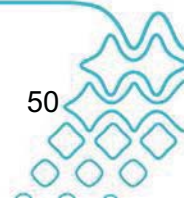
SECTION E
SUPERVISOR'S OVERALL EVALUATION

Please circle the appropriate box.

Unsatisfactory	Serious concerns about intern's competencies and/or rate of progress. Among other possibilities, further actions could be recommendations for remedial action that includes repetition of part or full placement
Uncertain or partially satisfactory	Some concerns about intern's competencies or variable/inconsistent performance/behaviour by intern. Recommendations could include brief and specific remedial assistance for intern, or further assessment to be organised by the training program
Satisfactory (Pass)	Intern has demonstrated competencies at or exceeding expected standards at this stage of training

Supervisor's Signature: **Date:**

Clinical Trainee's Signature: **Date:**



Appendix D – Example Automated Report

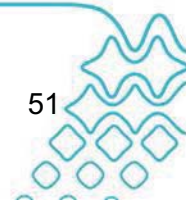
End-Placement Review Report

Clinical Trainee:	Test Trainee
Primary Supervisor:	Test Supervisor
Additional Supervisor/s:	Test Supervisor 2
Date of Placement - from/to:	
21/03/11	20/12/11
Placement hours completed as part of the clinical degree before this placement began:	200
Placement Agency:	Placement Agency
Client Population/s:	Client Populations
Setting:	Setting
Placement Type/s:	Placement Type
Therapeutic Approach/es:	CBT , DBT , ACT

*****NOTE** - It is important to recognise that numerical ratings reported below DO NOT equate to a mark (ie, 4.5 does not equate to 45 or fail; and 8.5 DOES NOT equate to 85 or High Distinction).

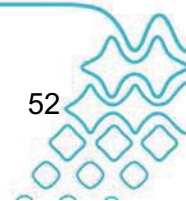
Numerical ratings signify a point (station) the student has reached along a continuum (journey) of development from “Beginner”(Stage 1) to “Competent Clinician” (Stage 4). Brief descriptions of these stages are provided in the table below. The ratings, on a scale from 1 to 10, represent your supervisor's best judgment in regards to your progress on your journey towards competence within each of the domains. Thus, students early in their training would be expected to obtain lower scores than students later in their training. If a practicum mark or grade is generated at your institution, these developmental ratings (along with other factors and assessment components) may be taken into account, but in no instance will they translate into numerical equivalents.

STAGES	DESCRIPTION OF CATEGORIES
STAGE 1. BEGINNER Range: 1-2	<i>Knowledge and skills are at an early stage or yet to be developed. Inadequate knowledge and/or difficulty applying knowledge to practice. Several problems or inadequacies occur during sessions. There may be an absence of key features, inability to prioritise issues or to make appropriate judgements. Little awareness of process issues. On par with Interns commencing training without any practicum experience. Regular and intensive supervision required.</i>
STAGE 2. Range: 3-5	<i>Some basic competencies in assessment and intervention, manages narrow range of clients with low levels of severity, using structured therapeutic activities. Performance is variable; major problems may occur occasionally; regular supervision required.</i>
STAGE 3. Range: 6-8	<i>Moderate repertoire of basic competencies in both assessment and intervention leading to management of a wider range of clients. Demonstrates understanding of underlying principles and a moderate ability to generalise these to new cases/situations. Performance can be improved in minor ways; less frequent supervision required.</i>
STAGE 4. COMPETENT Range: 9-10	<i>Large repertoire of basic to advanced competencies in both assessment and intervention, applied across range of clients and severity levels. Performance has reached competency levels on a par with a clinical psychologist working in their first job upon qualification.</i>



1. Relational skills - Overall Rating	
<i>Includes ability for empathic understanding, application of basic counselling techniques, and collaborative goal formulation with clients.</i>	9
a) Ability to form and communicate an empathic understanding to clients, carers, and significant others.	9
b) Ability to apply basic counselling techniques appropriately including clarification, paraphrase and summarisation responses.	9
c) Ability to use active and responsive listening skills	9
d) Ability to formulate client goals in a collaborative manner.	9
Comments:	

2. Clinical Assessment Skills - Overall Rating	
<i>Includes ability to perform adequate assessments in a time efficient and in a personally/socio-culturally sensitive manner. Ability to demonstrate appropriate diagnostic skills, prioritise issues, and assess risk.</i>	8.5
a) Efficiency in conducting an adequate assessment.	8.5
b) Ability to apply appropriate breadth of questioning to cover important issues including a mental state examination.	8.5
c) Ability to apply appropriate depth of questioning to ensure adequate understanding of key issues.	8.5
d) Ability to use a hypothesis testing framework effectively.	8.5
e) Ability and skill to make correct diagnoses and differential diagnoses.	8.5
f) Ability to undertake assessments in a socio-culturally sensitive manner.	7
Comments:	



Appendix E – Selected Vignette Domains

Note. This is a sample of domains 1 – Counselling Skills, and 6 – Response to Supervision and Progress During Placement. For more information on other domains, please contact the primary researcher. For an example of online presentation, please view the online samples, web address available within report.

Domain 1 – Counselling Skills

Stage 4 – Competent

Trainee D relates to clients effectively in *both* simple and complex client situations. She/he maintains a comfortable, warm, respectful and confident demeanour that assists the client to feel understood and at ease. She/he demonstrates genuine reflective listening skills and makes appropriate emotional and meaningful responses that assist in validating and clarifying issues for the client. She/he appropriately directs and guides client focus.

Stage 3

Trainee R relates to clients effectively in *simple* client situations and this capability is *developing* in more complex cases. She/he maintains a comfortable, warm, respectful and confident demeanour with most clients. She/he frequently demonstrates genuine reflective listening skills and makes appropriate emotional and meaningful responses that assist in validating and clarifying issues for the client. She/he appropriately directs and guides client focus in most cases.

Stage 2

Trainee I relates to clients effective in *most* simple client situations but experiences difficulties in more complex cases. She/he experiences difficulty in maintaining a warm, respectful and confident demeanour due to a focus on self performance or other factors. She/he demonstrates genuine reflective listening skills and makes appropriate emotional and meaningful responses in some cases. However, she/he may sometimes reinforce poor coping strategies by confusing empathy with sympathy. She/he may have difficulties in appropriately directing and guiding client focus.

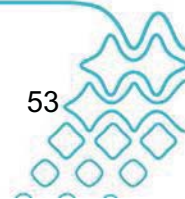
Stage 1 – Beginner

Trainee B is mostly self focused and so has difficulty relating within *most* client situations. She/he experiences difficulty in maintaining a warm and respectful demeanour and may appear overly rigid and/or inflexible. She/he appears to understand the need to use reflective listening skills and of making appropriate emotional and meaningful responses, but she/he fails to translate these into practice in a reliable manner. She/he uses a method of guiding client focus that mostly lacks collaboration with the client.

Domain 6 – Response to Supervision and Progress During Placement

Excellent progress

Trainee A has a mature, open, and positive attitude towards supervision, perceiving it as an opportunity to acquire new ideas, to consolidate learning, and to discuss one's approach to clients, and one's positive and negative feelings and reactions to the placement. She/he has a high level of motivation and prepares well for supervision and other practicum activities. The trainee is reflective and self-aware, and has a relatively accurate appraisal of one's capabilities. Supervisory sessions are pleasant, collaborative, professional, and effective. Overall, the trainee has made accelerated progress during the placement, much above the rate of progress expected of peers at a similar stage of training.



Good Progress

Trainee B is receptive and responsive to feedback in supervision but needs some support when the feedback is not positive. The trainee engages well with the supervisor and typically comes well prepared to supervision. He/she can switch from accepting direction in less confident areas to designing and sharing her/his own suggestions at other times. The trainee has a fairly good understanding of their own clinical skills, although at times there is evidence of being over-critical or over-confident. Consistent and good progress has been achieved during the placement. The rate of progress matches expectations for peers at a similar stage of training.

Modest Progress

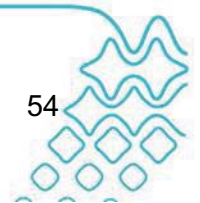
Trainee C comes across as dependent and anxious in supervision. The trainee typically gets bogged down in the detail, seeking clear direction or excessive reassurance for specific actions. Because of the trainee's agenda for supervision is typically dominated by immediate needs for the next client session, there is less than optimal focus on broader competencies and medium-term goals. Trainee anxiety has an adverse affect on being present for the client, and impairs reflectivity and growth towards independence. She/he is prone to self-doubt but is also conscientious, ready to work hard, keen to impress, and motivated to learn. Modest progress has been achieved across most domains during the placement. The rate of progress is slightly below the rate expected of peers at a similar stage of training.

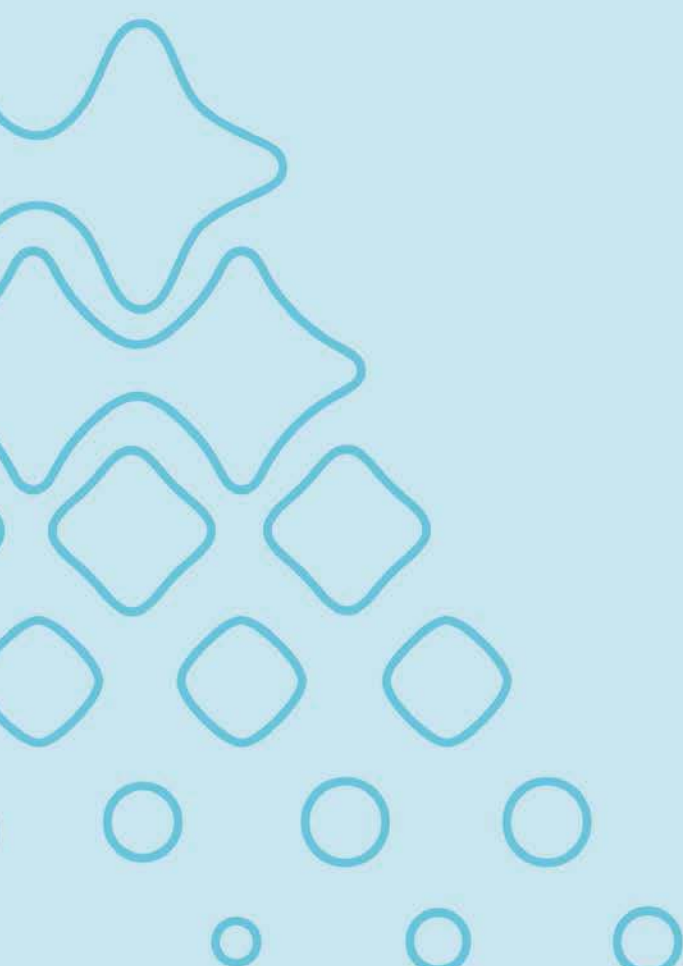
Inconsistent Progress

Trainee D. The supervisory relationship with Trainee D is characterised by episodes of engagement and commitment followed by periods when the supervisee appears disengaged and/or poorly motivated. Alternatively, supervisee competency and/or commitment can vary across domains with relatively adequate attention and improvement in some domains and concurrent neglect of significant others. Further, the trainee is less receptive and responsive to supervisor interventions. Overall, progress has been inconsistent or patchy across time and/or domains, with poor progress in one or more important domains.

Limited progress or no progress

Trainee E. Supervision with Trainee E is made difficult by the trainee's defensiveness or distress to feedback that is not positive. This makes the supervisor's accurate appraisal of the trainee's strengths and needs difficult. Alternatively, the trainee fails to prepare for supervision, and generally shows limited motivation to learn. Opportunities for learning through observation (e.g., DVD recordings) are often avoided or procrastinated. Significant supervisory resources are spent in dealing with barriers to progress that may include an unrealistic positive appraisal of their competencies and/or unrealistic demands that staff resolve the trainee's difficulties. Overall, progress is considerably slower than the rate expected of peers at a similar stage of training.





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