Competency framework for the UK Clinical Neuropsychology profession

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Author affiliations

Dr Ingram Wright, MA (Cantab), Ph.D, DclinPsych, Consultant Clinical Neuropsychologist, Head of Neuropsychology, Directorate of Neurosciences, Frenchay Hospital, North Bristol NHS Trust

Dr Zoe Fisher, Bsc, Ph.D, DclinPsych, Clinical Psychologist in Neuropsychology, Neuropsychology Department, Directorate of Neurosciences, Frenchay Hospital, North Bristol NHS Trust

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Key stakeholders have also played a vital role in the validation of the framework including clinical psychology and educational psychology training programmes, Clinical Psychologists, Educational Psychologists, and relevant voluntary sector organisations, professional allied to clinical neuropsychology and special interest groups related to neuropsychology.

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1. Executive Summary

This document reports the development of a competency framework for the UK profession of Clinical Neuropsychology.

The purpose of developing a competency framework was as follows:

- to develop standards for Clinical Neuropsychology practice in the UK;
- to objectively regulate entry to the specialism of Clinical Neuropsychology in the UK (entry to the Division of Neuropsychology's specialist register);
- to identify the expected competencies developed by candidates undertaking the Qualification in Clinical Neuropsychology (QiCN).

Two competency frameworks have been developed; one for paediatric neuropsychology and the other for adult neuropsychology. The frameworks aim to specify competencies required to practice paediatric and adult neuropsychology.

Within the frameworks competencies are represented across four domains:

1. Underpinning Knowledge and Skills
2. Clinical Work
3. Communication
4. Personal and Professional Practice

Each of the four domains is further divided into the following competency types:

a) Generic Clinical Competences
b) Neuropsychological Competencies

Initial competencies were derived from key sources including syllabus material for the Qualification in Clinical Neuropsychology (QiCN), learning objectives from existing clinical neuropsychology training courses, published competencies for UK Clinical and Educational Psychology, and core neuropsychology textbooks. The frameworks were further enhanced via meetings with Expert Reference Groups. These groups were comprised of experts working in distinct areas of clinical neuropsychology practice. Feedback obtained was used to adapt the frameworks and develop the content previously underrepresented.

The validity of the frameworks was assessed via QiCN vivas in order to ensure that competencies that were being assessed were appropriately represented within the frameworks. Clinical neuropsychologists, key stakeholders in neuropsychology and an Expert Consultation Group were then...
formally invited to comment on the draft frameworks. The frameworks were modified as a result of the feedback received during this consultation process.

This report describes the process of developing the frameworks and presents a summary of each framework. The frameworks can be accessed via [www.neuropsychcompetencies.org](http://www.neuropsychcompetencies.org) alongside detailed exemplars of practical application and self-assessment tools. Finally, the document will consider the way in which the framework can be implemented and consider organisational issues around its application.

2. Background

2.1: What is Clinical Neuropsychology?

Clinical Neuropsychology overlaps employing a scientific understanding of the relationship between brain and neuropsychological function within an applied clinical context. This approach forms the basis for assessment and rehabilitation of people with brain injury, or other neurological disease. Clinical Neuropsychologists work with people of all ages with neurological problems including traumatic brain injury, stroke, toxic and metabolic disorders, tumours and neurodegenerative disease.

Clinical Neuropsychologists require not only generic clinical skills and knowledge of the broad range of mental health problems, but also a substantial degree of specialist knowledge in the neurosciences to support competent assessment of neurological patients. Treatment and rehabilitation approaches encompass a broad range of specialist emotional, behavioural and cognitive interventions not only for the client, but also for the client’s family and carers. Clinical Neuropsychologists are also often involved in the management of services, and in individual case management. Leadership of multidisciplinary teams frequently forms part of their role of a Clinical Neuropsychologist.

Clinical Neuropsychologists most commonly work in the following settings:

- **Acute hospital:** working alongside neurosurgeons and neurologists and the allied disciplines, usually in a regional neurosciences centre. In this context, Clinical Neuropsychologists are particularly concerned with the early effects of trauma, neurosurgery and neurological disease.
- **Community or hospital based rehabilitation services:** providing post-acute assessment, training and support for people who have sustained brain injury, or who have other neurological problems. The clinical neuropsychologist is likely to play a central role in a multidisciplinary team which aims to maximise recovery, minimise disability, and prepare the client for return to the community or to a residential placement.
- **Educational services:** supporting assessment and management of educational and associated social and emotional development in children with identified or suspected neurological or neurodevelopmental conditions
- **Independent sector:** A growing number of Clinical Neuropsychologist work independently of the NHS or Local Education Authority. Private practice is well established in delivering rehabilitation following acquired brain injury. Experienced Clinical Neuropsychologists also commonly act as expert witnesses for the courts.
2.2: Why develop a competency framework for Clinical Neuropsychology?

The purpose of developing a competency framework was:

- to develop standards for Clinical Neuropsychology practice;
- to objectively regulate entry to the Division of Neuropsychology’s specialist register and any future statutory registration;
- to identify the expected competencies developed by candidates undertaking the Qualification in Clinical Neuropsychology (QiCN).

The framework has been developed at a crucial time for the evolution of Clinical Neuropsychology as a discrete discipline in the UK. It will potentially allow Health Professional Council issues and professional regulation issues to be addressed objectively. It will also support the development of professional roles for Clinical Neuropsychologists and the further development of the formal Qualification in Clinical Neuropsychology (QiCN).

3. The Process of developing a competency framework for Clinical Neuropsychology

3.1: Commissioning the project

The project supporting the development of the competencies framework was commissioned by the Division of Neuropsychology of the British Psychological Society (DoN). The DoN recognised the need to develop a framework to support recognition and promotion of appropriate standards for professional practice. Funding for the project supported the appointment of a part-time Clinical Psychologist.

The project was overseen by a pre-existing working party appointed by the Division of Neuropsychology. Members of the working party were all Clinical Neuropsychologists who work in diverse settings within the clinical neuropsychology profession. Representation also included the Committee for Training in Clinical Neuropsychology (CTCN), Clinical Neuropsychology Qualifications Board (CNQB) and the Division of Neuropsychology Executive. For a list of members of the working party see Appendix 1. The working party was chaired by the project lead, Dr Ingram Wright, and Dr Zoe Fisher was appointed to assist in the day-to-day running of the project.

Figure one shows an Illustration of the process of developing the competency frameworks for Clinical Neuropsychology
Figure 1: Illustration of the process of developing the competency frameworks for Clinical Neuropsychology
3.2: The Development Process

3.2.1: How the competencies required to practice Clinical Neuropsychology were identified

In the initial stages of the project competencies required to practice clinical neuropsychology were derived from the following sources:

- QiCN Candidate Handbook (detailing the curriculum content and required experience forming part of the QiCN process)
- QiCN Supervisors Handbook
- Competencies in Clinical Psychology
- Competencies in Educational Psychology
- US competencies in Clinical Neuropsychology
- Core text books in Neuropsychology
- Learning objectives and exam papers for accredited PGDip/MSc courses (Glasgow, Bristol and ICH/UCL courses)

Structural aspects of the framework were addressed with reference to the following documents:

- UK Neurology competency framework
- World Health Organisation
- DoH Knowledge and Skills Framework

The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders (Department of Health, Improving Access to Psychological Therapies (IAPT) Programme, 2007)

In order to practice clinical neuropsychology in the UK, it is necessary to first complete doctoral training in clinical psychology for adult neuropsychological practice, and clinical or educational psychology in the case of paediatric clinical neuropsychology. Thus clinical and educational psychology forms the foundation for subsequent specialist training and practice in clinical neuropsychology. When developing the framework for clinical neuropsychology a key decision was to incorporate the core clinical/educational psychology competencies rather than to assume clinical/educational psychology skills and experience as a prerequisite. The adult neuropsychology competency therefore includes references to all of the core competencies in clinical psychology; although some competencies have been reworded such that they are more specific to neuropsychology. Similarly, the paediatric neuropsychology framework includes reference to all of the clinical and educational core competencies regarded as relevant to the practice of clinical neuropsychology.

3.2.2: Oversight and peer review during the development phase

Expert Reference Group
After competencies had been identified from the sources highlighted above, two Expert Reference Groups were established; one for Paediatric Clinical Neuropsychology and the other for Adult Clinical Neuropsychology. The groups comprised of Clinical Neuropsychologists working in a variety of different settings in both the NHS, LEA and the independent sector. Several members of the Expert Reference Groups were examiners and supervisors for the QiCN. There was also representation from the directors for the MSc/PgDip courses in both Adult and Paediatric Clinical Neuropsychology.

For a list of clinicians who attended the Expert Reference Groups see Appendix Two. The Expert Reference Groups met with the project lead, the working party and the research psychologist on two occasions. A fundamental aim was to agree a structure within which to present the identified competencies. The group additionally scrutinised the first draft of the framework and to reach consensus with respect to changes that need to be made.

QiCN Examiners
The draft framework was also piloted during the Spring and Summer QiCN vivas in order to determine whether competencies being referenced by examiners were adequately represented within the framework. During the vivas some competencies were identified as poorly represented and appropriate changes were therefore made. Further feedback was obtained regarding the utility of the framework and how it could be navigated identified within the time available to examiners. Following the vivas, the framework was modified to include missing competencies and the structure of the framework was altered to facilitate easy identification of competencies.

3.3: The Consultation Process

The purpose of the consultation phase was to present the revised second version of the framework to Clinical Neuropsychologists and Clinical Psychologists in neuropsychology, key stakeholders in clinical neuropsychology and an Expert Consultation Group comprised of established experts in clinical neuropsychology, these experts had no prior involvement with the development of the framework.

Clinical Neuropsychologists

Clinical Neuropsychologists were contacted via: -

- The QiCN supervisor network
- Committee for Training in Clinical Neuropsychology (CTCN) mailing list
- Division of Neuropsychology mailing list
- Regional Special Interest Groups in Clinical Neuropsychology

Stakeholders

Key stakeholders in clinical neuropsychology invited to comment on the competency frameworks including the following groups: -

- Professional networks relevant to clinical neuropsychology practice
- Voluntary organisations relevant to service users
Other clinical professionals allied to clinical neuropsychology
Special interest groups

For a comprehensive list of key stakeholders see Appendix Two. Version two of the draft competency frameworks was published via a website and Clinical Neuropsychologists, key stakeholders in clinical neuropsychology and an Expert Consultation Group were invited by email to comment on the framework via an online survey. The survey questions were identified by the project lead, the research psychologist and the working party. See Appendix Three for the survey questions and results.

Expert Consultation Group
A group of Clinical Neuropsychologists with established expertise in a number of different areas were identified by the working party and invited to join the Expert Consultation Group. Expert Consultation Group members had not been involved in the development of the framework prior to this point (See Appendix Three for a list of Expert Consultation Group Members).

Version two of the competency framework was also sent to examiners of the QiCN and the Expert Reference groups for their comments on the changes that had been made to the frameworks.

3.3.1: Results of the consultation process
The data obtained via the consultation process were divided into the above three groups for the purpose of analysis.

Of the people invited to comment on the framework 74 responded (34 Clinical Neuropsychologists, 29 stakeholders including 18 Clinical Psychologists, two Educational Psychologists, and 5 allied professionals). Corporate responses were received from the Association of British Neurologists, three responses from the voluntary sector.

Of the clinical neuropsychologists who responded via the online survey 18% commented on the paediatric framework, 76% on the adult framework and the small remainder commented on both frameworks.

Overall, 92% of respondents agreed that it was important to develop a framework. The majority of clinicians agreed that framework would be helpful in informing curriculum development on the DClin/DEdPsych (78%) while 91% felt that the framework would be helpful to neuropsychology trainers in informing course curriculum for Clinical Neuropsychology and the QiCN. The usefulness of the framework was also recognised as applicable to newly qualified clinical psychologists specialising in clinical neuropsychology (86%). The majority clinicians (85%) also recognised that the framework would be helpful for QiCN candidates in order to self-appraise their competence.

Overall, 83% of respondents understood how the competencies represented within the framework could be reflected in practice, 7% neither agreed nor disagreed with the statement and 10% disagreed or strongly disagreed with the statement. The majority of respondents felt that the competency framework included ‘about the right amount of detail’. However, 20% felt there was too much detail while 16% felt there was too little detail provided within the competency framework.
82% of respondents agreed that the current framework defined the competencies that they would expect from a Clinical Neuropsychologist. It should be noted that a large number of these respondents were not Clinical Neuropsychologists. With respect to those that disagreed, a later question in the survey asks respondents to specify competencies they feel ought to be included or omitted to improve the framework.

Respondents were asked an optional open question about how they might find the framework helpful. Consistent themes identified across responses were that the framework would be helpful for the purpose of continued professional development and in informing the supervision of others working in the field of clinical neuropsychology. It was also felt that the framework was helpful in clarifying the differences between clinical psychology and clinical neuropsychology.

Details of the response patterns and responses to open-ended questions are included in Appendix Three.

4. The Competency Framework for Clinical Neuropsychology

When designing the competency framework it was critical to think about how the document would be utilised in practice as its function should be reflected in its structure. It was envisaged that the framework would be of most use to examiners during the QiCN vivas, Supervisors and candidates pursuing training. It was therefore necessary that the competencies could be identified quickly within the structure.

It was decided that the competencies required to practice clinical neuropsychology should be summarised on single ‘competency map’ providing a global overview of the required competencies. It was also envisaged that candidates undertaking the QiCN or supervising candidates undertaking the QiCN could use the competency framework to guide them. The framework has two levels. Level one summarises the competencies required to practice clinical neuropsychology on an A4 ‘competency map’ and level two provides additional details regarding each competency including illustrative examples.

It was important to find a meaningful way to structure all of the competencies required to practice clinical neuropsychology such that navigation of the framework would be quick and intuitive. The competency framework also reflects the training undertaken by clinical neuropsychologists and the day to day practice of clinical neuropsychology.

Both the adult and the paediatric competency frameworks were therefore divided into four broad domains. The first, ‘Underpinning knowledge and skills’ mostly reflects competencies acquired through formal training. The remaining competencies largely reflect competencies employed by clinical neuropsychologist on a day-to-day basis: -

1) Underpinning Knowledge and Skills: Competencies represented within the ‘Underpinning Knowledge and Skills’ domains are those relating to the theoretical understanding of clinical neuropsychology, research methods and relevant aspects of clinical psychology, neurosciences and other related disciplines. Typically, these skills are predominantly acquired through an undergraduate degree in psychology, academic coursework undertaking during training in clinical psychology, experience of designing, carrying out and presenting research, (for example, DClinPsych thesis), and through the QiCN process.
2) **Clinical Work**: Competencies represented in the ‘Clinical Work’ domain relate to effective interpersonal, assessment, formulation and intervention skills with individuals, teams and systems. Competencies also relate to the ability to utilise neuropsychological knowledge and experience in the delivery of assessment, formulation and intervention.

3) **Communication**: Competencies represented in the ‘Communication’ domain relate to effective communication in teaching, training, consultancy and broader professional practice and the ability to utilise neuropsychological knowledge and experience in communication with clients and professional colleagues.

4) **Personal and Professional Practice**: Competencies represented within the ‘Personal and Professional Practice’ domain relate to the understanding of psychological processes in a broad professional context and the ability to use such understanding in all collaborative strategic aspects of client work and service delivery. Specific neuropsychological competencies relate to the ability to refer to and make use of contextual legislative and organisational aspects of neuropsychology practice.

Each of the four domains was further sub-divided into ‘Generic Clinical’ competencies and more specialist ‘Neuropsychological Competencies’. This further division facilitates faster navigation of the framework by allowing the reader to identity generic clinical skills that lay the foundations for specialist practice and those that are specific to clinical neuropsychology.

a) **Generic Clinical Competences** – Competencies represented under the ‘Generic Clinical’ heading tend to relate to skills in Clinical (and Educational Psychology in the paediatric framework) which are the general foundations of specialist practice.

b) **Neuropsychological Competencies** – Competencies represented under the ‘Neuropsychology Competencies’ heading typically relate to skills that underpin and are specific to, clinical neuropsychology in all areas of practice (i.e. across different services and client presentations).

Figure 2: Shows the level 1 summary for the competency framework for the UK Clinical Neuropsychology Profession

Figure 3: Competency Map for Paediatric Clinical Neuropsychology

Figure 4: Competency Map for Adult Clinical Neuropsychology
<table>
<thead>
<tr>
<th>Competency Framework for Clinical Neuropsychology</th>
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<tbody>
<tr>
<td>1) Underpinning Knowledge and Skills</td>
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<tr>
<td>2) Clinical Work</td>
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<tr>
<td>3) Communication</td>
</tr>
<tr>
<td>4) Personal and Professional Practice</td>
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</tbody>
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**A) Generic Clinical Skills**
- With reference to theory and empirical evidence synthesise complex relevant information within a clinical supervisory, or research context.
- Demonstrate effective interpersonal, assessment, formulation and intervention skills with individuals, teams and systems. Demonstrate appropriate links between assessment, formulation and intervention.
- Demonstrate effective communication in teaching, training, consultancy and broader professional practice.
- To understand psychological processes in a broad professional context and use such understanding in a collaborative strategic aspects of client work and service delivery.

**B) Neuropsychological Competencies**
- Demonstrate detailed and broad knowledge of clinical neuropsychology and its theoretical foundations, clinical application and relationship with related aspects of clinical psychology, neuroscience and other related disciplines.
- Utilise neuropsychological knowledge and experience in the delivery of assessment, formulation and intervention.
- Utilise neuropsychological knowledge and experience in communication with clients and professional colleagues.
- Refer to and make use of contextual legislative and organisational aspects of neuropsychology practice.
1) UNDERPINNING KNOWLEDGE & SKILLS

A. Generic Clinical Skills

Ability to:
1.1. critically review & clinically apply research evidence
1.2. design & carry out research, service evaluations & audit
1.3. listen & demonstrate self-awareness & sensitivity
1.4. think scientifically critically, reflectively & evaluatively
1.5. work effectively whilst holding in mind alternative, competing explanations from the bi-psycho social spectrum
1.6. make judgements on complex issues, often in the absence of complete information
1.7. exercise personal responsibility & autonomous initiative in complex & unpredictable situations
1.8. generalise & synthesise prior knowledge/experience & apply critically & creatively in different settings

Understanding of:
1.9. the supervision process for supervisee & supervisor roles & provide supervision at an appropriate level within one’s own sphere of competence
1.10. relevant psychological theory
1.11. theories/models of leadership & change processes, & their application to service development & delivery

B. Neuropsychological Competencies

Knowledge of:
1.12. fundamental principles underpinning neuroscience
1.13. normal aging, brain pathology/injury & neurological recovery
1.14. conceptual approaches adopted in clinical neuropsychology & their historical foundations
1.15. contemporary theories of brain/behavioural relationships & their implications for clinical practice
1.16. psychometric & statistical principles
1.17. methods, terminology & conceptual approaches of clinical medical disciplines allied to clinical neuropsychology
1.18. advances in neuroscience research/practice & its implications for neuropsychological theory/practice
1.19. contemporary models/frameworks of health, disability & participation
1.20. all aspects of common neuropsychological, neurological & neuropsychiatric conditions

2) CLINICAL WORK

A. Generic Clinical Skills

Ability to:
2.1. develop & sustain professional relationships as an independent practitioner
2.2. work effectively in multi-disciplinary teams
2.3. work effectively with formal service systems & procedures
2.4. adapt practice to specific organisational context
2.5. choose, use & interpret a broad range of assessment methods appropriate to the client & service delivery system in which the assessment takes place & to the intervention which is likely to be required
2.6. use evidence to assess, formulate psychologically with clients, carers & service systems.
2.7. develop formulations to integrate assessments findings and psychological & neuropsychological theory & practice
2.8. direct, co-ordinate, support or facilitate teams together with an understanding of the principles of operation within a multidisciplinary or management team
2.9. recognise when intervention is inappropriate, or unhelpful, & communicating this sensitively
2.10. select & implement methods to evaluate the effectiveness of interventions & use this information to shape practice & inform service development.

Knowledge of:
2.11. factors which must be considered when selecting an intervention, & monitoring the expected outcome procedures by which the progress of & outcomes of an intervention may be assessed

B. Neuropsychological Competencies

Ability to:
2.12. interpret, analyse & synthesise evidence to inform clinical judgement
2.13. engage in regular consultation in the context of reviewing the clinical data
2.14. develop an understanding of the social, psychological & neurological processes underlying the clinical presentation
2.15. use formulation, & devise & deliver evidence based & tailored neuropsychological interventions
2.16. use formulation, & devise & deliver evidence based & tailored neuropsychological interventions
2.17. use formulation, & devise & deliver evidence based & tailored neuropsychological interventions
2.18. apply principles of management & rehabilitation of neuropsychological/neurological disorders
2.19. use knowledge & understanding of treatment approaches & management of a range of common neuropsychological, neurological & neuropsychiatric conditions
2.20. understand the role of clinical neuropsychology in mental health services

3) COMMUNICATION

A. Generic Clinical Skills

Ability to:
3.1. prepare & deliver teaching & training which takes into account the needs of the participants
3.2. demonstrate sound knowledge of the principles of report writing & other aspects of professional communication
3.3. communicate psychologically-informed ideas & conclusions clearly & effectively to specialist & non-specialist audiences
3.4. demonstrate understanding of consultancy models & the contribution of consultancy to practice

B. Neuropsychological Competencies

Ability to:
3.5. communicate neuropsychological hypotheses & conclusions clearly & effectively to specialist & non-specialist audiences
3.6. adapt style of communication to people with a wide range of neuropsychological disorders with differing levels of cognitive ability, sensory acuity & modes of communication
3.7. adapt communication & level of detail used in communication depending on the audience
3.8. provide feedback to clients/systems clearly & sensitively
3.9. understand the process of providing expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings
3.10. supporting others’ learning in the application of neuropsychological skills, knowledge, practices & procedures
3.11. engage & communicate with assistant psychologists in supervising the effective use of psychometric assessment tools & techniques, behavioural observation & elementary rehabilitation
3.12. use neuropsychological formulations to assist multi-professional communication
3.13. Accommodate additional medical information from various sources

4) PERSONAL & PROFESSIONAL PRACTICE

A. Generic Clinical Skills

Ability to:
4.1. understand ethical issues & apply this knowledge in complex clinical contexts
4.2. manage own personal learning needs & develop strategies for meeting these needs
4.3. appreciate the power imbalance between practitioners & clients and how abuse of this can be minimised
4.4. understand the impact & implications of differences, diversity & social inequalities on people’s lives
4.5. understand the impact & implications of differences, diversity & social inequalities on people’s lives
4.6. use supervision to reflect on practice, & make appropriate use of feedback received
4.7. develop strategies to handle the emotional & physical impact of own practice
4.8. work collaboratively & constructively with fellow psychologists, other colleagues & users of services
4.9. monitor & maintain health, safety, & security
4.10. work effectively at an appropriate level of autonomy, with awareness of the limits of one’s own competence
4.11. exercise duty of care with regard to safeguarding vulnerable groups
4.12. understand legislative & national planning context of service delivery & practice

B. Neuropsychological Competencies

Knowledge of:
4.13. formal documents in relation to ethical principles of practice, legal & statutory obligations & general professional standards as applied to clinical neuropsychology practice
4.14. the political & organisational context of health care delivery as it relates to neuropsychological clients, as well as relevant aspects of NHS & Social Services procedures
4.15. the differing requirements for neuropsychology in a range of contexts including private practice
4.16. general professional issues, & developments in professional arrangements & practice within a national & international context

ADULT FRAMEWORK
### UNDERPINNING KNOWLEDGE & SKILLS

#### A. Generic Clinical Skills

**Ability to:**

| 1.1 | critically review & clinically apply research evidence |
| 1.2 | design & carry out research, service evaluations & audits |
| 1.3 | listen & demonstrate self-awareness & sensitivity |
| 1.4 | think scientifically, reflectively & evaluatively |
| 1.5 | work effectively whilst holding in mind alternative, competing explanations from the bio-psycho social spectrum |
| 1.6 | make judgements on complex issues, often in the absence of complete information |
| 1.7 | exercise personal responsibility & autonomous initiative in complex & unpredictable situations |
| 1.8 | generalise & synthesise prior knowledge/experience & apply critically & creatively in different settings |

#### Understanding of:

| 1.9 | the supervision process for supervisee & supervisor roles & provide supervision at an appropriate level within one's own sphere of competence |
| 1.10 | relevant psychological theory |
| 1.11 | theories/models of learning & change processes, & their application to service development and delivery |

#### B. Neuropsychological Competencies

**Knowledge of:**

| 2.1 | historical & theoretical foundations of developmental cognitive neuroscience |
| 2.2 | neuropsychological theories & paradigms relevant to the study of developmental brain/behaviour relationships |
| 2.3 | major theories of brain/motor development & how they inform approaches to neuropsychological assessment & interpretation of data |
| 2.4 | neuroanatomical development of each sensory, motor & cognitive neural system & the integration of systems |
| 2.5 | major theories of normal cognitive learning & brain development |
| 2.6 | competing processes involved in restoration after early injury or abnormal compensation within each neural, cognitive or motor system at different stages of development |
| 2.7 | the relationship between underlying neuropsychological & cognitive outcomes & the health of the child/young person |
| 2.8 | psychometric & statistical principles |
| 2.9 | contemporary models/frameworks of health disability participation |
| 2.10 | all aspects of common neuropsychological, neurological, neurodevelopmental & neuropsychiatric conditions |
| 2.11 | specialist assessment for infants & children at risk of developmental delay |

**Ability to:**

| 2.12 | develop & sustain professional relationships as an independent practitioner |
| 2.13 | work effectively in multidisciplinary teams & contribute a psychological perspective |
| 2.14 | work effectively with formal service systems & procedures |
| 2.15 | adapt practice to a range of organisational contexts |
| 2.16 | bring about change for individuals, children, young people & their families by working at different levels of engagement, children, young people & their carers in assessment & decision-making processes, & in the evaluation of interventions & service delivery |
| 2.17 | choose, use & interpret a broad range of assessment methods appropriate to the client & service delivery system in which the assessment takes place & to the type of intervention required |
| 2.18 | use evidence to assess & formulate psychologically with children, young people, carers & systems |
| 2.19 | develop formulations to integrate assessments findings with psychological & neuropsychological theory |
| 2.20 | direct, co-ordinate, support or facilitate multidisciplinary or management teams |
| 2.21 | recognise when (further) intervention is inappropriate, or unhelpful, & communicate this sensitively |
| 2.22 | select & implement methods to evaluate interventions & use information to shape practice & deliver services |
| 2.23 | factors which must be considered in selecting an intervention, & monitoring the expected outcome |
| 2.24 | procedures by which the progress of & outcomes of an intervention may be assessed |

### CLINICAL WORK

#### A. Generic Clinical Skills

**Ability to:**

| 3.1 | provide & deliver teaching & training which takes into account the needs of the participants |
| 3.2 | demonstrate sound knowledge of the principles of report writing & other aspects of professional communication |
| 3.3 | communicate psychologically-informed ideas & conclusions clearly & effectively to specialist & non-specialist audiences |
| 3.4 | demonstrate understanding of consultancy models & the contribution of consultation to practice |

#### B. Neuropsychological Competencies

**Ability to:**

| 3.5 | communicate effectively with children & young people of different developmental ages with a wide range of neuropsychological disorders & differing levels of cognitive ability, sensory acuities & modes of communication |
| 3.6 | adapt clinical & non-clinical communication from a neuropsychological perspective in a style appropriate to a variety of different audiences |
| 3.7 | provide expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 3.8 | present neuropsychological formulations to assist multi-professional communication & understanding |
| 3.9 | understand the process of providing expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 3.10 | demonstrate sound knowledge of neuropsychological & neurological conditions & organisational skills |
| 3.11 | support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 3.12 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 3.13 | cope with the process of providing expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 3.14 | accommodate additional medical information from various sources |

### COMMUNICATION

#### A. Generic Clinical Skills

**Ability to:**

| 4.1 | understand ethical issues & apply this knowledge in complex clinical contexts |
| 4.2 | manage own personal learning needs & develop strategies for meeting these needs |
| 4.3 | appreciate the power imbalance between practitioners & clients & how abuse of this can be minimised |
| 4.4 | understand the implications of differences, diversity & social inequalities on people’s lives |
| 4.5 | understand the impact of one’s own value base, attitude and behaviour on clinical practice & service users |
| 4.6 | use supervision to reflect on practice, & make appropriate use of feedback received |
| 4.7 | develop strategies to handle the emotional & physical impact of own practice |
| 4.8 | work collaboratively & constructively with fellow psychologists, other colleagues & users of services |
| 4.9 | monitor & maintain one’s own safety, health, & security |
| 4.10 | work effectively at an appropriate level of autonomy, within the limits of one’s own competence |
| 4.11 | exercise duty of care with regard to safeguarding children & other vulnerable groups |
| 4.12 | understand legislative & national planning context of service delivery & practice |
| 4.13 | demonstrate effective professional management & organisational skills |
| 4.14 | demonstrate professional & ethical practice |

#### B. Neuropsychological Competencies

**Ability to:**

| 4.15 | support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.16 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.17 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.18 | provide expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 4.19 | cope with the process of providing expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 4.20 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.21 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.22 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.23 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.24 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 4.25 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |

### PERSONAL & PROFESSIONAL PRACTICE

#### A. Generic Clinical Skills

**Ability to:**

| 5.1 | understand ethical issues & apply this knowledge in complex clinical contexts |
| 5.2 | manage own personal learning needs & develop strategies for meeting these needs |
| 5.3 | appreciate the power imbalance between practitioners & clients & how abuse of this can be minimised |
| 5.4 | understand the implications of differences, diversity & social inequalities on people’s lives |
| 5.5 | understand the impact of one’s own value base, attitude and behaviour on clinical practice & service users |
| 5.6 | use supervision to reflect on practice, & make appropriate use of feedback received |
| 5.7 | develop strategies to handle the emotional & physical impact of own practice |
| 5.8 | work collaboratively & constructively with fellow psychologists, other colleagues & users of services |
| 5.9 | monitor & maintain one’s own safety, health, & security |
| 5.10 | work effectively at an appropriate level of autonomy, within the limits of one’s own competence |
| 5.11 | exercise duty of care with regard to safeguarding children & other vulnerable groups |
| 5.12 | understand legislative & national planning context of service delivery & practice |
| 5.13 | demonstrate effective professional management & organisational skills |
| 5.14 | demonstrate professional & ethical practice |

#### B. Neuropsychological Competencies

**Knowledge of:**

| 5.15 | understanding the relationship between patterns of cognitive function & appropriate learning intervention |
| 5.16 | understand the relationship between cognitive impairment & educational progress & attainment |
| 5.17 | understand treatment & management of a range of developmental & acquired neurological conditions |
| 5.18 | demonstrate sound knowledge of the principles of report writing & other aspects of professional communication |
| 5.19 | demonstrate understanding of consultancy models & the contribution of consultation to practice |
| 5.20 | cope with the process of providing expert neuropsychological opinion & advice, including the preparation & presentation of evidence in formal settings |
| 5.21 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.22 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.23 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.24 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.25 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.26 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.27 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.28 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.29 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |
| 5.30 | present neuropsychological formulations to support others’ learning in the application of neuropsychological skills, knowledge, practices & procedures |

### PAEDIATRIC FRAMEWORK
5. Applying the Framework

The framework is designed to support the UK Clinical Neuropsychology profession in defining the expected competencies for practitioners in the NHS and in independent practice. The application of the framework is likely to be most evident in the evaluation of competencies developed through the current QiCN examination and training routes. However, additional applications of the framework will include implementation to support service commissioning, career progression and developments in primary and post-qualification training in clinical neuropsychology.

5.1: Do clinicians need to do everything specified in a competence list? Do senior clinicians need to do anything more than is specified in the competence framework?

The competency framework is specifically focussed on competencies developed at the entry level to Clinical Neuropsychology practice. The application of the framework to the QiCN will involve delivery of a range of competencies at the fundamental level. The presence of all developed competencies at a basic level is therefore likely to be considered the entry level threshold.

Many candidates taking the QiCN will already have a wealth of experience in related applied psychology specialities. Some competencies will therefore already be present at an advanced level. Candidates are expected to progress to develop substantial experience in management and service development beyond the QiCN. Further development of advance competencies is therefore expected and is reflected in some aspects of the competency framework. However, the development of managerial and service development competencies is relevant to applied psychology practice but not specifically related to neuropsychology speciality. Further managerial and leadership competencies may therefore be developed but are outwith the scope of the framework.

5.2: Are some competencies more important than others?

The examples of competencies provided within the framework are intended to be practically useful illustrations rather than comprehensive lists. These examples will be updated over time in consultation with the Division of Neuropsychology and as course curricula and services expectations develop.

We anticipate that core competencies in all areas will ensure that candidates have requisite transferable skills to take up posts across the range of neuropsychology services. However, the relevance and relative weighting of competencies will depend on the requirements of any specific job or service role. Therefore, we expect that the particular demands of a service context and individual role will lead to some competencies being more important than others and the relative strength of such competencies evolving over time.

5.3: How does educational and clinical training /PFMQ/QICN supervision and work experience map onto this framework?

The mapping of competencies from clinical training and QiCN processes was a fundamental part of the framework development. However, the depiction of the framework does not explicitly separate these competencies as the training process requires the synthesis of pre-existing general and more specific neuropsychological competencies. Depending upon the desired implementation of the framework,
considered. The implementation of the competency framework will, in this regard be useful in addressing the need to maintain the quality of the speciality while also allowing a greater diversity of training provision to deliver competencies at a level of the QiCN.

Further implementation of the competency framework will be in the development of self-evaluation tools for QiCN trainees and others who are keen to assess their developing competencies. Similar to those tools developed in relation to CBT competencies we propose that self-evaluation tools to support candidates, supervisors and experienced clinicians with regard to CPD need analysis.

6.3: Service commissioning
Commissioning guides for clinical neuropsychology services are available with reference to both adult and paediatric services. The establishment of a competency framework will help to inform commissioning managers about the potential role that Clinical Neuropsychologists can play in service delivery. Appropriate dissemination of clinical neuropsychology commissioning materials should therefore include explicit reference to the competency framework.

6.4: Job description, appraisals and development review
A separate DoN workstream was initiated linking neuropsychology training and career progression to explicit A4C bandings and KSF profiles. This work is, as yet, incomplete. The publication of the competency framework should be linked to professional guidance on appropriate remuneration for applied psychologists practicing Clinical Neuropsychology in the NHS and educational sector. Furthermore, guidance should be issued to managers on the application of the framework and associated assessment tools to any appraisals and development review processes which may influence career progression.

6.5: Evolution of competency frameworks
The competency framework will need to evolve alongside the growth and development of the speciality of Clinical Neuropsychology. Mechanisms for minor updates the framework should be built into processes of the CNQB and CTCN within the Division of Neuropsychology. Examples of application to illustrate the individual competencies is a specific area for development. We suggest that such examples are routinely derived from anonimised comments of QiCN examiners via the CNQB.

In practice, we recommend the development of a standards group within the DoN to oversee proposed minor revisions to the documentation on a regular basis.

References
Competencies in Clinical Psychology. BPS committee for Scrutiny of Individual Clinical Qualifications
Competencies mapping document for Doctoral programmes in Clinical Psychology (doc)
Competencies mapping document for Doctoral programmes in Educational Psychology in England, Northern Ireland & Wales (doc)
The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process (October 2004)
MSc Learning Objectives (University of Glasgow, University of Bristol, Institute of Child Health - University College London.)

Reports of the INS/Division 40 Task Force on Education, Accreditation and Credentialing.


National Academy of Neuropsychology approved definition of a clinical neuropsychologist. American Academy of Clinical Neuropsychology (AACN) Practice Guidelines for Neuropsychological Assessment and Consultation

The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders (Department of Health, Improving Access to Psychological Therapies (IAPT) Programme, 2007)

World Health Organisation, International Classification of Functioning, Disability and Health.

## Appendix One: Working Party Members

<table>
<thead>
<tr>
<th>Working Party Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr Ingram Wright (Chair)</strong></td>
</tr>
<tr>
<td><strong>Professor Jonathan Evans</strong></td>
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<tr>
<td><strong>Dr Sal Connolly</strong></td>
</tr>
<tr>
<td><strong>Dr Philippa Griffiths</strong></td>
</tr>
<tr>
<td><strong>Dr Tracey Ryan Morgan</strong></td>
</tr>
<tr>
<td><strong>Dr Arleta Starza-Smith</strong></td>
</tr>
<tr>
<td><strong>Dr Jacki Bambrough</strong></td>
</tr>
</tbody>
</table>
# Appendix Two: Expert Reference Group Members

<table>
<thead>
<tr>
<th>Members of the Paediatric Expert Reference Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr Ingram Wright (Chair)</strong>  Consultant Paediatric Neuropsychologist, Department of Neuropsychology, Neurology Unit, Frenchay Hospital, Frenchay Park Road, Bristol, BS16 1LE</td>
</tr>
<tr>
<td><strong>Judith Middleton</strong>  Consultant Paediatric Neuropsychologist, Oxford.</td>
</tr>
<tr>
<td><strong>Dr Fergus Gracey</strong>  Clinical Neuropsychologist and Practitioner Researcher NIHR CLAHRC for Cambridgeshire and Peterborough, Douglas House, 18b Trumpington Road, Cambridge, CB2 8AH.</td>
</tr>
<tr>
<td><strong>Ms Shauna Kearney</strong>  Consultant Paediatric Neuropsychologist, Paediatric Psychology Department, Birmingham Children's Hospital, Steelhouse Lane, Birmingham, B4 6NH</td>
</tr>
<tr>
<td><strong>Dr Peter Rankin</strong>  Consultant Paediatric Neuropsychologist, Department of Clinical Neuropsychology, Great Ormond Street, Children's NHS Hospital, London, WC1N 3JH</td>
</tr>
<tr>
<td><strong>Mr Steve Whitfield</strong>  Consultant Paediatric Neuropsychologist, Neuropsychology Associates Court Hill House, 60 Water Lane, Wilmslow, Cheshire, SK9 5AJ</td>
</tr>
<tr>
<td><strong>Jody Warner-Rogers</strong>  Clinical Paediatric Psychologist, 113 Lavenham Road, Southfields, London, SW18 5ER</td>
</tr>
<tr>
<td><strong>Arleta Starza-Smith</strong>  Consultant Paediatric Neuropsychologist, Queens Medical Centre, Nottingham</td>
</tr>
<tr>
<td>Name</td>
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<td>-----------------------------</td>
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<tr>
<td>Dr Ingram Wright (Chair)</td>
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<td></td>
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<tr>
<td>Professor Jonathan Evans</td>
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<td></td>
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<tr>
<td>Dr Rudi Coetzer</td>
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<td></td>
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<tr>
<td>Ms Katherine Carpenter</td>
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<td>Dr Camilla Herbert</td>
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<td></td>
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<td>Professor Julie Snowden</td>
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<td></td>
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<td>Dr Andy Tyerman</td>
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<td>Dr Martin Bunnage</td>
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<td>Dr Giles Yeates</td>
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<td>Dr Rupert Noad</td>
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<td>Dr Sal Connolly</td>
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<td></td>
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<tr>
<td>Dr Fergus Gracey</td>
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<tr>
<td></td>
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<tr>
<td>Professor Laura Goldstein</td>
</tr>
</tbody>
</table>
Dr Kit Pleydell-Pearce  
University of Bristol, 6-8 Priory Road Clifton, Bristol, BS8 1TZ

Professor Rodger Wood  
Consultant Clinical Neuropsychologist and Professor of Neuropsychology, Brain Injury Research Group, Swansea University, Singleton Park, Swansea, SA2 8PP, South Wales.

Dr Jody Warner-Rogers  
Clinical Paediatric Neuropsychologist, 113 Lavenham Road, Southfields, London, SW18 5ER

Dr Gavin Newby  
Consultant Clinical Neuropsychologist, South Cheshire ABI Service, Acorn Suite, 1829 Building, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1HJ

Professor Narinda Kapur  
Consultant Clinical Neuropsychologist and Honorary Professor of Neuropsychology, Research Department of Clinical, Educational and Health Psychology University College London Gower Street London WC1E 6BT

Dr Sue Copstick  
Professional Lead for Neuropsychology, Floor 3, Institute of Neurological Sciences, Southern General Hospital, Glasgow, G51 4TF

Dr Shauna Kearny  
Consultant Clinical Paediatric Neuropsychologist, Paediatric Psychology Dept, Birmingham Childrens Hospital, Steelhouse Lane, Birmingham, B4 6NH

Members of the Expert Consultation Group
Appendix Three: Online Survey Questions

**Question One** - “The competency framework will be useful/beneficial...”

Respondents were asked whether they felt the framework would be helpful in a variety of clinical and training contexts.

**Table 1** percentage of clinical neuropsychologists responding to the prompt

<table>
<thead>
<tr>
<th>Clinical Neuropsychologists (n = 29)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>in informing DClin curriculum planning</td>
<td>3 %</td>
<td>12 %</td>
<td>12 %</td>
<td>44 %</td>
<td>29 %</td>
</tr>
<tr>
<td>to newly qualified clinical psychologists specialising in neuropsychology</td>
<td>3 %</td>
<td>6 %</td>
<td>6 %</td>
<td>44 %</td>
<td>41 %</td>
</tr>
<tr>
<td>to QiCN candidates in self-appraisal of competencies</td>
<td>6 %</td>
<td>6 %</td>
<td>9 %</td>
<td>41 %</td>
<td>38 %</td>
</tr>
<tr>
<td>to neuropsychology trainers in developing course curriculum</td>
<td>0 %</td>
<td>9 %</td>
<td>6 %</td>
<td>38 %</td>
<td>47 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 %</td>
<td>3 %</td>
<td>21 %</td>
<td>29 %</td>
<td>32 %</td>
</tr>
<tr>
<td></td>
<td>9 %</td>
<td>0 %</td>
<td>38 %</td>
<td>15 %</td>
<td>14 %</td>
</tr>
<tr>
<td></td>
<td>6 %</td>
<td>6 %</td>
<td>15 %</td>
<td>29 %</td>
<td>35 %</td>
</tr>
</tbody>
</table>

**Table 2**: key stakeholders responding to the prompt

<table>
<thead>
<tr>
<th>Stakeholders (n = 28)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In informing DClin curriculum planning</td>
<td>6 %</td>
<td>6 %</td>
<td>6 %</td>
<td>72 %</td>
<td>11 %</td>
</tr>
<tr>
<td>to newly qualified clinical psychologists specialising in neuropsychology</td>
<td>5 %</td>
<td>0 %</td>
<td>11 %</td>
<td>42 %</td>
<td>42%</td>
</tr>
<tr>
<td>to QiCN candidates in self-appraisal of competencies</td>
<td>5 %</td>
<td>0 %</td>
<td>5 %</td>
<td>47 %</td>
<td>42 %</td>
</tr>
<tr>
<td>to neuropsychology trainers in developing course curriculum</td>
<td>0 %</td>
<td>0 %</td>
<td>0 %</td>
<td>67 %</td>
<td>33 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7 %</td>
<td>7 %</td>
<td>14 %</td>
<td>64 %</td>
<td>7 %</td>
</tr>
<tr>
<td></td>
<td>0 %</td>
<td>8 %</td>
<td>67 %</td>
<td>33 %</td>
<td>0 %</td>
</tr>
<tr>
<td></td>
<td>6 %</td>
<td>0 %</td>
<td>29 %</td>
<td>47 %</td>
<td>18 %</td>
</tr>
</tbody>
</table>
Table 3: Expert Reference Group or Expert Consultation Group members

<table>
<thead>
<tr>
<th>Expert Group (n = 11)</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>In informing DClin curriculum planning</td>
<td>0 %</td>
<td>0 %</td>
<td>18 %</td>
<td>55 %</td>
<td>27 %</td>
</tr>
<tr>
<td>To newly qualified clinical psychologists specialising in neuropsychology</td>
<td>0 %</td>
<td>0 %</td>
<td>9 %</td>
<td>45 %</td>
<td>45 %</td>
</tr>
<tr>
<td>To QiCN candidates in self-appraisal of competencies</td>
<td>0 %</td>
<td>0 %</td>
<td>9 %</td>
<td>9 %</td>
<td>81 %</td>
</tr>
<tr>
<td>To neuropsychology trainers in developing course curriculum</td>
<td>0 %</td>
<td>0 %</td>
<td>9 %</td>
<td>18 %</td>
<td>73 %</td>
</tr>
</tbody>
</table>

Overall, the majority of clinicians (78%) agreed that framework would be helpful in informing the curriculum for the Doctorate in Clinical Psychology. The majority of clinicians (86%) also agreed that the framework would be helpful for newly qualified clinical psychologists specialising in clinical neuropsychology. Overall, 85% of clinicians agreed or strongly agreed that the framework would be helpful for QiCN candidates in order to self appraise their competence. Ninety-one percent of clinicians felt that the framework would be helpful to neuropsychology trainers in informing course curriculum.

Question one also specifically asked those who supervised trainee clinical psychologists on specialist neuropsychology placements (n = 16) whether the framework would be helpful to them. Of these supervisors, 94% agreed or strongly agreed that the framework would be helpful. Question one asked those who were QiCN supervisors (n = 9) whether the framework would be helpful to them in their supervisory role; 100% strongly agreed. Finally, question one asked QiCN examiners (n = 7) whether the framework would be helpful in this capacity, 86% agreed.

**Question Two**
Respondents were asked whether they could understand how the competencies would be reflected in practice. Table four summaries the data of those who responded.

Table 4

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinical Neuropsychologists</th>
<th>Stakeholders in Clinical Neuropsychology</th>
<th>Expert Consultation and Expert Reference Group</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>0 %</td>
<td>4 %</td>
<td>0 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Disagree</td>
<td>13 %</td>
<td>4 %</td>
<td>9 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>10 %</td>
<td>7 %</td>
<td>0 %</td>
<td>7 %</td>
</tr>
<tr>
<td>Agree</td>
<td>43 %</td>
<td>59 %</td>
<td>36 %</td>
<td>49 %</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>33 %</td>
<td>8 %</td>
<td>55 %</td>
<td>34 %</td>
</tr>
</tbody>
</table>
Overall, 83% of respondents understood how the competencies represented within the framework could be reflected in practice, 7% neither agreed nor disagreed with the statement and 10% disagreed or strongly disagreed with the statement.

**Question Three**
Respondents were asked whether they felt the competency framework was appropriately detailed. Table five summarises the responses.

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinical Neuropsychologists</th>
<th>Stakeholders in Clinical Neuropsychology</th>
<th>Expert Consultation and Expert Reference Group</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too detailed/specific</td>
<td>20 %</td>
<td>15 %</td>
<td>18 %</td>
<td>18%</td>
</tr>
<tr>
<td>About right</td>
<td>53 %</td>
<td>85 %</td>
<td>82 %</td>
<td>70%</td>
</tr>
<tr>
<td>Too general/vague</td>
<td>27 %</td>
<td>0 %</td>
<td>0 %</td>
<td>12%</td>
</tr>
</tbody>
</table>

Overall, 12% of respondents felt the competency framework was ‘too vague/general’, 18% respondents felt the framework was ‘too detailed/specific’ and 70% felt that the framework was ‘about right’.

**Question Four**
Respondents were asked whether they felt the competency framework gave too much detail, too little detail or about the right amount of detail. Table six summaries the data for those who responded to the question.

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinical Neuropsychologists</th>
<th>Stakeholders in Clinical Neuropsychology</th>
<th>Expert Consultation and Expert Reference Group</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much too much detail</td>
<td>3 %</td>
<td>4 %</td>
<td>9 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Somewhat too much detail</td>
<td>17 %</td>
<td>8 %</td>
<td>9 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Slightly too much detail</td>
<td>0 %</td>
<td>12 %</td>
<td>0 %</td>
<td>4 %</td>
</tr>
<tr>
<td>About the right amount of detail</td>
<td>50 %</td>
<td>73 %</td>
<td>72 %</td>
<td>63 %</td>
</tr>
<tr>
<td>Slightly too little detail</td>
<td>10 %</td>
<td>4 %</td>
<td>9 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Somewhat too little detail</td>
<td>10 %</td>
<td>0 %</td>
<td>0 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Much too little detail</td>
<td>10 %</td>
<td>0 %</td>
<td>0 %</td>
<td>4 %</td>
</tr>
</tbody>
</table>

Overall, the majority of respondents felt that the competency framework included ‘about the right amount of detail’. However, 20% felt there was too much detail and 16% felt there was too little detail provided within the competency framework.

**Question Five**
Respondents were asked whether they felt the competency framework would be useful/beneficial to services.

| Table 7 |
Overall, 75% of respondents agreed that the framework would be useful/beneficial to services, 12% neither agreed nor disagreed and 16% disagreed or strongly disagreed.

**Question Six**
Respondents were asked whether they felt it was important to develop a competency framework for clinical neuropsychology.

**Table 8**

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinical Neuropsychologists</th>
<th>Stakeholders in Clinical Neuropsychology</th>
<th>Expert Consultation and Expert Reference Group</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>10 %</td>
<td>11 %</td>
<td>0 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Disagree</td>
<td>10 %</td>
<td>0 %</td>
<td>0 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>10 %</td>
<td>11 %</td>
<td>18 %</td>
<td>12 %</td>
</tr>
<tr>
<td>Agree</td>
<td>48 %</td>
<td>67 %</td>
<td>73 %</td>
<td>59%</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>21 %</td>
<td>15 %</td>
<td>9 %</td>
<td>16%</td>
</tr>
</tbody>
</table>

Overall, 92% of respondents agreed or strongly agreed that it was important to develop a framework whereas 5% disagreed.

**Question Seven**
Respondents were asked whether they felt that the current framework defined the competencies that they would expect from a clinical neuropsychologist. Table 9 summaries the data.

**Table 9**

<table>
<thead>
<tr>
<th>Response</th>
<th>Clinical Neuropsychologists</th>
<th>Stakeholders in Clinical Neuropsychology</th>
<th>Expert Consultation and Expert Reference Group</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>3 %</td>
<td>0 %</td>
<td>0 %</td>
<td>2 %</td>
</tr>
<tr>
<td>Disagree</td>
<td>14 %</td>
<td>4 %</td>
<td>9 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>7 %</td>
<td>13 %</td>
<td>0 %</td>
<td>8 %</td>
</tr>
<tr>
<td>Agree</td>
<td>31 %</td>
<td>63 %</td>
<td>36 %</td>
<td>44 %</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>45 %</td>
<td>21 %</td>
<td>55 %</td>
<td>38 %</td>
</tr>
</tbody>
</table>
Overall, 82% of respondents agreed that the current framework defined the competencies that they would expect from a clinical neuropsychologist. It should be noted that a large number of these respondents were not clinical neuropsychologists. With respect to those that disagreed, a later question in the survey asks respondents to specify competencies they feel ought to be included or omitted to improve the framework.

**Optional Open-Ended Questions**

**Question eight**
Respondents were asked an optional open question about how they might find the framework helpful. Consistent themes identified across responses were that the framework would be helpful for the purpose of continued professional development and in informing the supervision of others working in the field of clinical neuropsychology. It was also felt that the framework was helpful in clarifying the differences between clinical psychology and clinical neuropsychology.

**Question 9, 10, 11 and 12**
Question nine asked respondents what they would expect a clinical neuropsychologist to do that was not adequately described within the framework. Question 10 asked respondents if they would like to suggest additional competencies that they felt ought to be considered for inclusion in the final framework. Question 11 asked respondents if they felt that any of the competencies included in the framework ought to be omitted and finally question 12 asked respondents if there was anything that they wanted to comment on with respect to the framework and its implementation. A summary of these comments can be found in Appendix Six. Where appropriate and possible all comments have been considered and reference is made alongside each of the comments to the place in the document or competency framework where the suggestion has been implemented.
Appendix Four: Key Stakeholders in Clinical Neuropsychology

Consultation Groups

1) Stakeholders in Clinical Neuropsychology including relevant voluntary organisations, other clinical professions allied to clinical neuropsychology
2) Special interest groups
3) Clinical neuropsychologist

1) Key Stakeholders invited to comment on the competency frameworks: -

Relevant voluntary organisations: -
- Headway
- The Stroke Association
- Multiple Sclerosis Society
- Alzheimer’s Society
- Child Brain Injury Trust
- Epilepsy Society
- Epilepsy Action
- Royal Hospital for Neuro-disability
- Parkinson’s UK
- Brain Tumour UK
- The encephalitis Society

Clinical professionals who work closely with clinical neuropsychologists: -
- Clinical Psychologists
- Educational Psychologists
- Neurosurgeons
- Neurologists
- Occupational Therapists
- Physiotherapists
- Speech and language therapists
- Clinical Psychologists
- Educational Psychologists
- Psychiatrists
- Nursing

2) Special Interests Groups
- PSIGE committee and members list
- British Neuropsychology Society (chair)
- British Neuroscience Association (chair)
- Paediatric Psychology Network UK

3) Clinical neuropsychologist
- QiCN supervisors
- Committee for Training in Clinical Neuropsychology (CTCN)
- Division of neuropsychology members
- Regional Special Interest Groups in Clinical Neuropsychology
## Appendix Five: Responses to optional open ended survey questions

Summary of comments in relation to whether respondents felt that the framework adequately reflected what they felt clinical neuropsychologists do

<table>
<thead>
<tr>
<th>Question Nine: What would you expect a clinical neuropsychologist to do that is not adequately described in the framework?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comments made by Clinical Neuropsychologist</strong></td>
</tr>
<tr>
<td>Providing input to mental health services</td>
</tr>
<tr>
<td>Acquired brain injury appears to be given more weighing than diseases such as MS, HD, PD and dementia (more frequently referred to). Add references to these diseases in section 2.13 and 4.13</td>
</tr>
<tr>
<td>Insight, ethical judgement, balancing clinical arguments with external pressures</td>
</tr>
<tr>
<td>Seeking consultation with more senior colleagues</td>
</tr>
<tr>
<td><strong>Comments made by Stakeholders in Clinical Neuropsychology</strong></td>
</tr>
<tr>
<td>Ability to remember to be a ‘human being’ and holistic and to not to limit input to one area (i.e. diagnostic assessment)</td>
</tr>
<tr>
<td>Add something about listening to others in to communication section</td>
</tr>
<tr>
<td>Add ‘private practice issues’ to ‘Personal and Professional Practice’ section</td>
</tr>
<tr>
<td>Make it clearer that the examples given are illustrations not comprehensive lists</td>
</tr>
<tr>
<td>Understanding of ageing and its impact on the brain</td>
</tr>
<tr>
<td>Understanding of issues relating to diversity (across testing/ theory) especially bilingualism</td>
</tr>
<tr>
<td><strong>Comments made by Expert Groups</strong></td>
</tr>
<tr>
<td>Ability to make strong links between assessment and intervention targets</td>
</tr>
<tr>
<td>More inclusion of understanding common neurological pathways in developmental conditions, links between genes, behaviour and cognition e.g. in systemic illness, liaison with CAMHS, differential diagnosis and management of behavioural/emotional difficulties and young offending behaviour and neuropsychological deficits.</td>
</tr>
<tr>
<td>Ability to make a strong link between assessment and intervention targets/methods. This is reflected well in the assessment process (e.g., Point 2.17), but less clear in the treatment aspects (though covered in part by Point 2.32)</td>
</tr>
</tbody>
</table>
Summary of comments in relation to whether respondents wished additional competencies to be considered for inclusion within the competency framework

**Question Ten: If you would like us to consider inclusion of additional competencies please give details here**

<table>
<thead>
<tr>
<th>Comments made by Clinical Neuropsychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.13's reference to acquired brain injury may be a little narrow, although probably representative of the majority of settings where clinical neuropsychologists work - awareness of the impact of other neurological disorders (e.g. MS) might be usefully included.</td>
</tr>
<tr>
<td>Perhaps some more concrete competencies with regard to intervention skills (adapted therapy approaches, cognitive remediation strategies??)</td>
</tr>
<tr>
<td>Administration of neuropsychological tests to clients with significant language/motor/sensory difficulties and guidance on computerised neuropsychological test administration/use</td>
</tr>
<tr>
<td>Impact of cultural/educational/philosophical orientations/upbringing on people and the impact this may have on their neurocognitive functioning</td>
</tr>
<tr>
<td>Understanding of the impact of one's behaviour and attitude on clients</td>
</tr>
<tr>
<td>Ability to manage services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments made by Key Stakeholders in Clinical Neuropsychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the paediatric framework I think that as well as reference to acquired brain injury, there should be equivalent reference to congenital brain injury/deformation.</td>
</tr>
<tr>
<td>Clinical competencies regarding systemic approaches and explicit competencies regarding engaging families and carers. Competencies regarding simplifying reading material eg “Easy read etc. added to the competencies sections.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments made by Expert Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many people will be working in a CAMHS setting and not in a tertiary Paediatric service - the competencies also need to reflect this</td>
</tr>
<tr>
<td>Maybe something related to Point 1.19 about assessment of “change over time” and issues relating to repeat assessments and monitoring of progress</td>
</tr>
<tr>
<td>Some of the skills covered in Kapur (2009) may be worth considering for inclusion.</td>
</tr>
</tbody>
</table>
Summary of comments in relation to whether respondents felt any specific competencies should be omitted

<table>
<thead>
<tr>
<th>Question 11: If you think specific competencies should be omitted, please reference these here</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comments made by Clinical Neuropsychologists</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td><strong>Comments made by Key Stakeholders in Clinical Neuropsychology</strong></td>
</tr>
<tr>
<td>There are competencies I feel take priority over others - this is likely to be very difficult to establish and thus all should stay even if not equal!</td>
</tr>
<tr>
<td>I think all the generic stuff could go, given that practitioner neuropsychologists must first qualify as clinical / educational psychologists anyway.</td>
</tr>
<tr>
<td><strong>Comments made by Expert Groups</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>
Question 12: Is there anything we have not asked you that you would like to comment about?

<table>
<thead>
<tr>
<th>Comments made by Clinical Neuropsychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider the role of neuropsychology in mental illness including understanding the relationship between brain functioning and mental illness and the implications for interventions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments made by Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>I appreciate the effort to reference educational psychology competencies, however overall the document still sounds very clinical</td>
</tr>
<tr>
<td>I would be concerned if the competencies become used as a barrier rather than a useful tool for continued professional development. In other words, it would be important to ensure that this framework will help service users have greater access to neuropsychology rather than less.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments made by Expert Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two points (3.5 and 3.7) understandably overlap with the “generic clinical skills” - but I imagine individuals without specialist training in neuropsych would argue that all clinicians can “communicate effectively with children and young people” Would it be possible to make some of these overlap areas more specific to include reference to neurological or neurodevelopment impairments that might impact on communication</td>
</tr>
<tr>
<td>My only comment is that level 2 of 2.13 is currently too individual-focused and out of step with the reality of these difficulties, the impact on those who generate service referrals as a result of such difficulties, and their social cost. You need to balance what you have already with reference to breakdown of family, social and work relationships and progressive social isolation for patients and significant others</td>
</tr>
</tbody>
</table>
DIMENSION ONE: UNDERPINNING KNOWLEDGE AND SKILLS

A. Generic Clinical Skills

1.1: Ability to critically review and clinically apply research evidence (Core Competencies in Clinical Psychology; Research Dimension 6, Competency 1; QiCN Practitioner Handbook, Appendix 3, Guidelines on Clinical Psychology Research).

Competency 1.1 includes the following: -

- Identify, review and critically appraise a substantial body of research evidence which is at the forefront of clinical psychology practice (Core Competencies in Clinical Psychology; Research Dimension 6, Competency 1).
- Demonstrate knowledge of neuropsychological constructs and neuropsychological theory as applied to clinical practice (QiCN Practitioner Handbook, Appendix 3, Guidelines on Clinical Psychology Research).

1.2: Ability to and carry out research, service evaluations and audit Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 2, 3, 4, 5, 6, 7 and Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 2).

Competency 1.2 includes the following: -

- Understand applicable techniques for clinical research and advanced academic enquiry, including quantitative and qualitative approaches (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 2).
- Conduct service evaluation and small N research (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 3).
- Conduct collaborative research (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 4).
- Conceptualise, design and conduct independent, original research of a quality to satisfy peer review, extend the forefront of the discipline, and merit publication: including identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis, reporting outcomes and identifying appropriate pathways for dissemination (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 5).
- Understand the need and value of undertaking clinical research and development post-qualification, contributing substantially to the development of theory and practice in clinical psychology (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 6).
- Auditing clinical effectiveness (Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 2).

1.3: Ability to listen and demonstrate self-awareness and sensitivity, and working as a reflective practitioner (Core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 3, Consultation Process, 2012).

1.4: Ability to think scientifically critically, reflectively and evaluatively (Core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 4) and work as a reflective scientist-practitioner (edited by expert reference group, 2011).

1.5: Ability to work effectively whilst holding in mind alternative, competing explanations (Core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 9) from the bio-psycho social spectrum (edited by expert reference group, 2011)

Click here to return to the competency map
1.6: Ability to make [informed] judgements on complex issues in specialist fields, often in the absence of complete information (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 5; word ‘informed’ removed by expert reference group, 2011)

1.7: Ability to exercise personal responsibility and largely autonomous initiative in complex and unpredictable situations [in professional practice] (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 7; ‘in professional practice’ removed by expert reference group)

1.8: Ability to generalise and synthesise prior knowledge and experience in order to apply critically and creatively in different settings and novel situations (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 2; ‘in professional practice’ removed by expert reference group)

1.9: Understanding of the supervision process for supervisee and supervisor roles (core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 4 and provide supervision at an appropriate level within own sphere of competence (core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 1)

1.10: Understanding of relevant psychological theory (QICN handbook, appendix 1 pp 25).

1.11: Understanding of theories and models of leadership and change processes, and their application to service development and delivery (core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 4 and 9).

B: Neuropsychological Competencies

1.12: Knowledge of the fundamental principles underpinning neuroscience (QICN Candidate Handbook, Appendix 1, pp 24-25; The Houston Conference on Speciality education and training in clinical neuropsychology)

Fundamental principles underpinning neuroscience include understanding the general principles of neuroanatomy, elementary neurophysiology, elementary neurochemistry and developmental neuroscience. Sufficient knowledge of the basic principles of neuroscience should be demonstrated for four purposes: to enable understanding of the neuroscience literature as it pertains to neuropsychological issues; to facilitate understanding of communications from colleagues working in allied disciplines; to appreciate the medical evidence as it relates to a particular client; to contribute to relevant discussions about the care, management and rehabilitation of particular clients. As important as this general knowledge is the ability to access sources of more detailed information which may be required in considering the case of an individual client (QICN Practitioner handbook, appendix 1 pp 24).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Knowledge in basic neuroanatomy may include an understanding of:
- the basic structure of neurons
- the main forms of neuron and classification of neurons by connections
- the main forms and function of glial cells
- the CSF circulatory system and main functions of CSF
- the main components and functions of the meninges
- the main blood vessels supplying the brain, draw and label a diagram of the Circle of Willis, and identify which regions of the brain are supplied by which major blood vessels.
- the main subdivisions of the brain
- the components of the limbic system

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)
Knowledge of basic neurochemistry may include an understanding of:

- the basic mechanisms of synaptic transmission
- the main neurotransmitters
- the acetylcholine transmitter system and the rationale for the development of acetylcholinesterase inhibitors in the treatment of cognitive impairments in dementia
- the structure and functions of the main neurotransmitter systems (serotonin, noradrenaline, dopamine, GABA, glutamate) and understand the most common implications of disruption to normal functioning of these systems
- the rationale for the development of drugs for protecting the brain after injury and the evidence for the effectiveness of these interventions.

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Knowledge of developmental neurology and neuropathology may include an understanding of:

- the main stages and processes in brain development
- the main disorders that disrupt brain development and describe how they affect the process of brain development

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Knowledge of elementary neurophysiology may include an understanding of:

- the electrical activity of the brain, nerves and muscles (Working Party, 2011)


Practitioners must have an understanding of plasticity in development and in response to trauma and other injuries, categories of neuropathology, demyelinating white matter disease, metabolic changes in response to neuropathology and metabolic conditions, neurotoxic process, effects of raised CNS pressure and hydrocephalus, infectious disease, monophasic and biphasic processes, acute/primary and post acute/secondary effects traumatic brain injury, degenerative conditions.

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Knowledge of brain pathology/injury may include an understanding of:

- the meaning of the term, ‘brain plasticity’ and the main potential mechanisms of brain reorganisation
- the effect of an ischaemic lesion on surviving tissue

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Knowledge of neurological recovery may include an understanding of:

- the potential benefit of grafting, nerve growth factor, and enriched environments in reducing secondary effects of primary lesion
- the rationale for targeting neurotransmitter systems, inhibitory molecules, stem-cell based therapies and neurogenesis as potential mechanisms of enhancing structural plasticity
- potential neuroprotection strategies are evaluated in animal models
- evidence in relation to the efficacy of potential acute neuroprotective drugs

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)
1.14: Knowledge of conceptual approaches adopted in clinical neuropsychology and their historical foundations

(QICN Practitioner Handbook, Appendix 1, pp 25-26)

Practitioners should be able to describe the theoretical bases for the procedures employed and conclusions reached both in terms of contemporary neuropsychological practice and, in lesser depth, in relation to prior practice. Some appreciation should be shown of the main historical schools of neuropsychology and the principal topics of neuropsychological research associated with various periods. The object of this aspect of the Underpinning Knowledge is to ensure that practitioners have an appreciation of the reasons why certain procedures are employed and certain data sought, and the reasoning behind the implications which are drawn from these data. Practitioners should be able to explain why certain procedures are employed in the assessment, management and rehabilitation of neuropsychological clients, to understand the theory on which these are based, and to discuss the process of evidential reasoning by which clinical neuropsychological practice is conducted.

Conceptual approaches adopted in neuropsychology include, localisation of function, behavioural neurology, normative approaches, lateral asymmetries, cognitive neuropsychology (including contemporary models/theories of attention, information processing, executive function, visual/perceptual frameworks etc), functional decomposition, single case studies, single and double dissociations

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Knowledge of cognitive neuropsychology may include the understanding of:-

- how information from single cases is used to build models of normal cognition in cognitive neuropsychology
- single dissociation and a double dissociation
- the contribution that cognitive neuropsychology models might make in planning neuropsychological assessment and rehabilitation interventions.
- Posner and Peterson's models of attention.
- the most widely cited models of frontal lobe/executive functioning, including those of Luria, Duncan, Baddeley, Norman and Shallice, Shallice and Burgess.
- the most common theoretical models of the process of memory consolidation

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Knowledge of the historical foundations of clinical neuropsychology may include an understanding of: -

- the major historical developments in the development of neuropsychological theory and practice (e.g. localisation of function, behavioural neurology, normative approaches, lateral asymmetries)
- the contribution made to development of neuropsychological theory and practice by key individuals including Gall, Broca, Wernicke, Brodmann, Sperry, Penfield, Wada, Luria
- how major shifts in neuropsychological thinking and theorising have occurred and appreciating the factors (including individuals) that have influenced these shifts in thinking

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)


Knowledge regarding the relationship between brain area and likely behavioural/cognitive outcomes. Knowledge regarding the relationship between brain pathology, performance on neuropsychological assessments and functional abilities.
Specific knowledge regarding brain behaviour relationships may include an understanding of:

- what cognitive functions might be affected by a right middle cerebral artery stroke
- what cognitive problems might be expected after a lesions to the left temporal lobe
- the extent to which neuropsychological tests selectively measure specific cognitive functions

1.16: Knowledge of psychometric and statistical principles (Expert Reference Group, 2011; The Houston Conference on Speciality education and training in clinical neuropsychology)

Knowledge of psychometric principles may include an understanding of:

- the purpose of expressing test scores using a common metric
- the most commonly used standard metrics (z scores, T scores, Standard Wechsler scores, IQ scores, Sten scores, Percentile Ranks)
- how to convert scores on one metric to another
- the concept of standard error of measurement and how it is calculated
- how one can determine whether test scores are reliably different
- the importance of the distinction between the reliability and abnormality of test score differences
- the base rate issue when multiple tests are employed
- the factors influencing attempts to measure change in test performance
- the use of regression in measuring change in the individual case
- the relative value of different sources of validity information in diagnostic testing
- the sensitivity and specificity of tests
- the role of base rates and the use of Bayes theorem in diagnostic testing

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

1.17: Knowledge of methods, terminology and conceptual approaches of the clinical medical disciplines allied to clinical neuropsychology (QiCN Candidate Handbook, Appendix 1, pp 24).

Practitioners must possess a general working knowledge of the methods, terminology and conceptual approaches of the clinical medical disciplines allied to clinical neuropsychology. These include, basic neuroanatomy (see competency 1.13), neuropathology (see competency 1.13), neuroradiology, principles of neurology, the neurological examination, neurosurgical procedures, neuropharmacology, paediatric neurology, electrophysiology and allied clinical disciplines (speech and language therapy; physiotherapy; occupational therapy; rehabilitation medicine; nursing)

Practitioners should possess a general working knowledge of the methods, terminology and conceptual approaches of the clinical medical disciplines allied to clinical neuropsychology. This should permit them to recognise the relevant procedures and investigations which have been undertaken, to evaluate the clinical reports of these procedures and investigations, and to understand their implications for clinical neuropsychological practice. They should understand the neuroscience basis for these interventions and examinations, be familiar with the nature of the procedures involved, and be able critically to evaluate the utility and limitations of the information which they provide.

Practitioners do not need to attain competence in the implementation of these procedures, or in interpretation of the data derived and it may lead them to exceed their competence should they do so. However, it is essential that relevant information provided by other clinical medical disciplines be understood, appropriately evaluated, and the implications for the neuropsychological functioning of an individual client be validly drawn. Practitioners should also have the ability to recommend that certain procedures and investigations be considered as likely to yield evidence which will be of value in their neuropsychological practice with reference to a particular client.

Click here to return to the competency map
Knowledge of the neuroradiology may include an understanding of: -

- the basic principles of, and the main differences between, the most common neuroimaging techniques (including CT, MRI, PET and SPECT)
- the differences between structural and functional neuroimaging and the use of these two forms of imaging technique
- how neuroimaging techniques contribute to diagnosis of neurological conditions
- the strengths and limitations of CT scan reports in relation to neuropsychological assessment

Knowledge of pharmacology may include an understanding of: -

- the acetylcholine transmitter system and the rationale for the development of acetylcholinesterase inhibitors in the treatment of cognitive impairments in dementia
- the rationale for the development of drugs for protecting the brain after injury and the evidence for the effectiveness of these interventions

Knowledge of electrophysiology may include an understanding of: -

- the basic principles of, and the main differences between, the most common neurophysiological techniques (electroencephalography [EEG], evoked potentials [EP] and electromyography [EM])
- how neurophysiological techniques contribute to diagnosis of neurological conditions

Knowledge of the neurological examination may include an understanding of: -

- the procedures involved in the neurological examination and the purpose of the neurological examination in the diagnosis of neurological disorders
- what information could be obtained from a report of a neurological examination to guide a neuropsychological assessment


Practitioners must be aware of the general principles of new advances in neuroscience research, conceptual developments concerning the organisation and functional operation of the human nervous system, their implications for neuropsychological theory and practice (QiCN Practitioner Handbook, Appendix 1, pp 24).

Knowledge of contemporary models/frameworks of health, disability and participation (Expert Reference Group, 2011).

Practitioners must be familiar with key frameworks of health, disability and participation for example, the International Classification of Functioning, Disability and Health [ICF], (World Health Organisation, 2001).
1.20: Knowledge of all aspects of common neuropsychological, neurological and neuropsychiatric conditions (QiCN practitioner handbook, Appendix 1, pp 26-28)

Practitioners must be able to provide evidence of substantial knowledge concerning all aspects of common neuropsychological disorders. Although it is recognised that in particular areas of clinical neuropsychological practice, some types of disorder will be more commonly the focus of clinical attention, the competent clinical neuropsychologist should have a basic working knowledge of the range of disorders listed above. With reference to each category of disorder, practitioners should possess a basic knowledge of: the neuropathology of the disorder; the epidemiology of the disorder; genetic and sociocultural factors associated with the disorder; its neuropsychological presentation and course; aspects of the disorder relevant to its assessment.

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Common neuropsychological disorders include (QiCN practitioner handbook, Appendix 1, pp 26-28; Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology): -

- Disorders of language including neurolinguistic disorders, the aphasias, alexia and agraphia and acalculia
- Disorders of perception and cognition including sensory perception disorders, body schema disorders, object recognition deficits, visual perception deficits, the agnosias (colour, face, object) and somaesthesias
- Disorders of attention and its components and spatial neglect
- Sensorimotor disorders including somatosensory processes, the apraxias and astereognosis
- Disorders of executive function such as disorders of organisation, planning, reasoning and conceptual dysfunction, problem solving
- Disorders of memory and learning including semantic memory, implicit memory, the amnesic syndrome, anterograde and retrograde amnesia, post traumatic amnesia (PTA) and specific memory loss
- Disorders of emotion and social behaviour including affective disturbances, anhedonia, disorders of motivation and initiation, disinhibition, aggression and asocial behaviour.
- Disorders of insight and awareness

Common neuropsychological disorders include (QiCN practitioner handbook, Appendix 1, pp 26-28; Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology): -

- Severe and profound brain injury including coma, low awareness and vegetative states
- Neuropsychology of degenerative conditions including dementia of the Alzheimer type, multi-infarct dementia, vascular dementia, dementia with Lewy bodies, frontal temporal dementia, multiple sclerosis, Parkinson's disease, Huntington's disease, motor neurone disease and acquired immune deficiency syndrome (AIDS)
- Neuropsychology of acquired brain injury including closed traumatic brain injury, penetrating traumatic brain injury, cerebrovascular disorders, alcohol and drug abuse, other neurotoxins, cerebral anoxia and cerebral infections
- Epilepsy and seizure disorders including classification of epileptic phenomena, neuropsychology of epilepsy, course of idiopathic/acquired epilepsy, neuropsychological implications of seizure events, neuropsychological implications of treatment: surgical/pharmacological and non-epileptic seizures
- Stroke including the classification of strokes (TACS/PACS/POCS/LACS), the incidence of different forms of stroke, the mechanisms of ischaemic and haemorrhagic stroke
- Tumour including the classification system for tumours, symptoms of brain tumour, challenges of early diagnosis and the neuropsychology of tumour
- Neuropsychology of neoplastic and systemic disorders
- Paediatric clinical neuropsychology including congenital disorders, developmental disorders, hyperactivity, attentional disorders, autism, Asperger's syndrome and acquired brain injury in children
- Encephalitis including knowledge of causes, pathology process and the neuropsychology of encephalitis
Common neuropsychiatric disorders include (QiCN practitioner handbook, Appendix 1, pp 26-28 and Expert Reference Group, 2011): -

A. Generic Clinical Skills

2.1: Ability to develop and sustain professional relationships as an independent practitioner

Competency 2.1 includes:

- Developing and maintaining effective working alliances with clients, including individuals, carers and services (Core Competencies in Clinical Psychology; ‘Psychological Assessment’ Dimension 9, Competency 8).
- Developing and sustaining relationships with team members, fellow psychologists, other health professionals and organisations (Expert Reference Group, 2011)

2.2: Ability to work effectively in multi-disciplinary teams (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 8).

2.3: Ability to work effectively with formal service systems and procedures (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 6).

2.4: Ability to adapt practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 6).

2.5: Ability to choose, use and interpret a broad range of assessment methods appropriate to the client and service delivery system in which the assessment takes place and to the type of intervention which is likely to be required (Core Competencies in Clinical Psychology; ‘Psychological Assessment’, Dimension 2, Competency 2).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

This includes assessment of mental health, cognitive function, the cognitive abilities underpinning driving, and capacity etc. Techniques include:

- formal procedures (use of standardised psychometric instruments)
- systematic interviewing procedures
- other structured methods of assessment (e.g. observation, or gathering information from others)
- assessment of social context and organisation
- using appropriate risk assessments to guide practice (Core Competencies in Clinical Psychology; ‘Psychological Assessment’ Dimension 2, Competency 4).

2.6: Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems (Core Competencies in Clinical Psychology; ‘Transferable Skills’ Dimension 1, Competency 1).

2.7: Develop formulations which integrate information from assessments within a coherent framework that draws upon psychological and neuropsychological theory (Core Competencies in Clinical Psychology; ‘Psychological Formulation’ Dimension 3, Competency 1).

2.8: Ability to direct, co-ordinate, support or facilitate teams together with an understanding of the principles of operation within a multidisciplinary or management team (QICN Practitioner Handbook, Appendix 1, pp 29)
2.9: Ability to recognise when (further) intervention is inappropriate, or unlikely to be helpful, and communicate this sensitively (Core Competencies in Clinical Psychology; ‘Psychological Intervention’ Dimension 4, Competency 7).

2.10: Ability to select and implement appropriate methods to evaluate the effectiveness, acceptability and broader impact of interventions at a service and organisational level, and using this information to inform and shape practice and service development. Where appropriate this will also involve devising innovative procedures (Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 1; ‘at a service and organisation level added by working party, 2011).

2.11: Knowledge of factors which must be considered in selecting an intervention and knowledge of barriers to intervention (QiCN Practitioner Handbook, Appendix 1, pp28-29)

2.12: Knowledge of procedures by which the progress of and outcomes from an intervention may be assessed at the client level [individuals, groups and families] (QiCN Practitioner Handbook, Appendix 1, pp 28-29).

B. Neuropsychological Competencies

General Neuropsychological Competencies

2.13: Ability to demonstrate a holistic understanding of the social, psychological, cognitive and vocational impact of acquired brain injury and neurological conditions both for individuals and systems (Expert Reference Group, 2011; Consultation Process, 2012)

*The term neurological condition includes progressive conditions such as Huntington's disease, Parkinson’s disease, multiple sclerosis and the dementias

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Specific example of knowledge in this area may include understanding: -

- the prevalence of behaviour problems after acquired brain injury/neurological impairment
- the range of factors that may contribute to the development of behaviour problems after acquired brain injury/neurological impairment
- how to assess problems of anger and aggression after acquired brain injury/neurological impairment
- the evidence base relating to the main approaches to the management of anger and aggression including pharmacological, psychological therapy and behaviour management approaches.
- the most common psychosocial consequences of acquired brain injury/neurological impairment including changes in personality and psychiatric disorders.
- The impact of acquired brain injury/neurological conditions on family functioning, personal, work and social relationships and community participation

2.14: Ability to identify cognitive impairment, behavioural changes and emotional difficulties and provide integrated psychological/neuropsychological approaches to manage these (Expert Reference Group, 2011)

2.15: Ability to understand structural organisation of neurorehabilitation services and the role of clinical neuropsychology within these services (QiCN Practitioner Handbook, Appendix 1, pp 20)

Practitioners must understand the principles of operation within a multidisciplinary rehabilitation or management team, as well as the role of a clinical neuropsychologist if required to direct, co-ordinate, support or facilitate such a multidisciplinary team. Practitioners must understand what might comprise a model neurorehabilitation service and the role of clinical neuropsychology within such a service.
Neuropsychological Assessment Competencies

2.16: Ability to use behavioural observations and to map them to possible neurological, cognitive or emotional underpinnings (Expert Reference Group, 2011).

2.17: Ability to perform clinical assessment including history taking, bedside cognitive assessment and mental status examination and carrying this through to management (Expert Reference Group, 2011).

2.18: Ability to tailor neuropsychological assessment to clients and to address appropriate questions (Expert Reference Group, 2011).

2.19: Ability to demonstrate familiarity with and select, administer and interpret a wide range of assessment instruments (QICN, Practitioner Handbook, Appendix 1, pp 26).

Familiarity with assessment instruments must include the general nature of the test instrument and its theoretical foundation, its development, standardisation and psychometric properties, the procedures for its application, scoring and interpretation, and an ability to derive and report valid conclusions from the application of the test. Practitioners must not only be familiar, in some depth, with a range of the most commonly employed procedures, but also should possess a more general appreciation of the wider range of tests which might appropriately be employed. They should be able to select instruments which are capable of providing valid and pertinent information relevant to the neuropsychological investigation, and be able to appreciate the limitations of the information so derived.

Practitioners should have an understanding about assessment of change over time and issues related to repeat assessment and monitoring progress/progression

2.20: Ability to understand psychometric principles underpinning the selection, administration and interpretation of cognitive test scores

Practitioners must provide evidence of a thorough and comprehensive knowledge of the assessment procedures adopted in clinical neuropsychology. They should already possess a sound knowledge of psychometric and statistical principles (see competency 1.16) and must in addition be familiar with an adequate range of the assessment instruments employed in general clinical neuropsychological practice. Practitioners must also show an understanding about the assessment of change over time and issues related to repeat assessment and monitoring progress.

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Knowledge of the psychometric principles underpinning the selection, administration and interpretation of cognitive tests scores may include an understanding of:

- test manuals and other published data in order to critically appraise the psychometric properties of commonly used neuropsychological tests
- the strengths and limitations of a range of commonly used cognitive tests
- the concept of reliability/stability of neuropsychological tests and how these are determined

2.21: Ability to describe the range of factors that could affect performance on neuropsychological tests (Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Practitioners must be able to interpret cognitive tests scores in the context of a broader well structured investigation and consider the impact of additional variables that could affect performance on cognitive test scores. For example, fatigue, sleep, mood, anxiety, effort, time of day, sensory/motor problems, cultural biases, normal aging, bilingualism, diversity etc
2.22: Working knowledge regarding the neuropsychological profiles associated with a range of common neuropsychological disorders

Practitioners must have knowledge of the neuropsychological profiles associated with a range of common neuropsychological disorders some of which are outlined in competency 1.20.

**Neuropsychological Formulation Competencies**

2.23: Ability to construct formulations about the client’s neuropsychological status by the deductive process of cognitive assessment in the course of a broader investigation (QiCN Practitioner Handbook, Appendix 1, pp26).

Practitioners must show an ability to construct and investigate hypotheses about the client’s neuropsychological status by the deductive application of appropriate test instruments in the course of a well-structured investigation. Practitioners must demonstrate the ability to reason neuropsychologically on the basis of a variety of sources of assessment data and provide a psychological description based upon complex neuropsychological data.

2.24: Ability to use neuropsychological formulations dynamically to facilitate a client’s understanding and adjustment and to plan interventions if required, coupled with the ability to revise formulations when necessary (Core Competencies in Clinical Psychology; ‘Psychological formulation’, Dimension 3, Competency 2, 3 and 5).

**Neuropsychological competencies in Rehabilitation and Intervention**

2.25: Ability to use formulation and devise and deliver evidence based and individually tailored psychological and or neuropsychological interventions with clients and/or systems

**Competency 2.25 is made up of the following Core Competencies in Clinical Psychology:**

- On the basis of a formulation, implementing neuropsychological, psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with: individuals; couples, families or groups and services/organisations (Core Competencies in Clinical Psychology; ‘Psychological intervention’, Dimension 4, Competency 1).

- Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, including those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating, psychosis and use of substances, and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations (Core Competencies in Clinical Psychology; ‘Psychological intervention’, Dimension 4, Competency 2).

- Ability to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological therapy, of which one must be cognitive-behaviour therapy (Core Competencies in Clinical Psychology; ‘Psychological intervention’, Dimension 4, Competency 3).

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- Understanding social approaches to intervention; for example, those informed by community, critical, and social constructionist perspectives (Core Competencies in Clinical Psychology; ‘Psychological intervention’, Dimension 4, Competency 5).

- Implementing interventions and care plans through and with other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements (Core Competencies in Clinical Psychology; ‘Psychological intervention’, Dimension 4, Competency 6).

2.26: Ability to adapt models of therapeutic intervention for psychological difficulty in the context of impaired cognitive functioning (Expert Reference Group, 2011).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

For example, in relation to brain injury and Cognitive Behavioural Therapy (CBT), practitioners must be able to critically appraise the rationale for the application of CBT in the context of brain injury with reference to integrative biopsychosocial models of the consequences of brain injury. Practitioners must be aware of the challenges to conducting CBT in the context of brain injury and understand the way in which CBT may be adapted to take account of deficits associated with brain injury. Practitioners must have a critical understanding of the evidence relating to the efficacy of CBT in the context of brain injury (Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

2.27: Ability to consider broader psychological interventions appropriate to the presenting ‘neuropsychological’ difficulty and to the psychological and social circumstances of the client(s)


Principles of recovery and rehabilitation include behavioural interventions, cognitive rehabilitation, pharmacological treatments for neuropsychological complaints, vocational rehabilitation, goal planning, personal and social effects of neurological disease, rehabilitation and disability counselling, impact upon relatives and carers, evaluation of outcome, understanding of rehabilitation services, knowledge of voluntary organisations.

Practitioners must exhibit knowledge of the principal theories which pertain to neurological recovery and to neuropsychological rehabilitation. They must be able to show a detailed knowledge of the procedures most commonly employed in the management and rehabilitation of clients, from a variety of psychological perspectives. They should have a working knowledge of pharmacological treatments for neuropsychological complaints. An appreciation must be shown of the factors which must be evaluated in selecting an appropriate intervention, and the likely outcomes of the interventions which may appropriately be considered. Practitioners must also demonstrate a working knowledge of the procedures which may be employed, and consideration of the factors which determine the precise form which the intervention will take. Flexibility in applying general intervention approaches, taking into account basic psychological and neuropsychological principles, is an important characteristic.
Knowledge of the principles and practice of neurorehabilitation may include an understanding of:

- the history of the development of ideas, approaches and methods in paediatric neuropsychological rehabilitation
- the WHO International Classification of Functioning (ICF)
- the difference between restorative and compensatory approaches to neuropsychological rehabilitation
- the difference between impairment-focused and activity (disability)-focused rehabilitation approaches to neuropsychological rehabilitation
- the evidence in relation to effectiveness of methods of rehabilitation for cognitive impairments
- literature relating to the use of goal setting in brain injury rehabilitation
- compensatory interventions according to cognitive systems, such as errorless learning;
- pharmacological and potentially restorative interventions.

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

2.29: Ability to use up to date knowledge and understand the treatment approaches and management for a range of common of neuropsychological, neurological and neuropsychiatric conditions (QiCN Practitioner Handbook, Appendix 1, pp 28-29)

See competency 1.20 for examples of common neuropsychological disorders, neurological and neuropsychiatric disorders.

2.30: Understand the role of clinical neuropsychology within mental health service (Consultation Process, 2012)
Dimension Three: Communication

A. Generic Clinical Skills

3.1: Ability to prepare and deliver teaching and training which takes into account the needs and goals of the participants (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 3).

3.2: Ability to demonstrate sound knowledge of the principles of report writing and other aspects of professional communication (QiCN Candidate Handbook, Appendix 1, pp 29).

3.3: Ability to communicate psychologically-informed ideas and conclusions clearly and effectively to specialist and non-specialist audiences (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 3).

3.4: Ability to demonstrate understanding of consultancy models and the contribution of consultancy to practice (Core Competencies in Clinical Psychology; ‘Service Delivery, Dimension 9, Competency 3).

B: Neuropsychological Competencies

3.5: Ability to communicate neuropsychological hypotheses and conclusions clearly and effectively to specialist and non-specialist audiences (Expert Reference Group, 2011).

3.6: Ability to adapt style of communication to people with a wide range of neuropsychological disorders with differing levels of cognitive ability, sensory acuity and modes of communication (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 2).

3.7: Ability to adapt communication and level of detail used in communication depending on the audience (Expert Reference Group, 2011; Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 1).

Competency 3.7 includes the ability to: - Communicate clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences [for example, to professional colleagues, and to service users and their carers] (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 1).

For example, ability to adapt and simplify reading materials for clients when appropriate

3.8: Provide (neuro) psychological feedback to clients/systems clearly and sensitively (Expert Reference Group, 2011).

3.9: Ability to understand the process of providing expert neuropsychological opinion and advice, including the preparation and presentation of evidence in formal settings (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 5 - modified to be specific to clinical neuropsychology).

3.10: Ability to support others’ learning in the application of neuropsychological skills, knowledge, practices and procedures (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 7).

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3.11: Ability to engage and communicate with assistant psychologists in supervising the effective use of psychometric assessment tools and techniques, behavioural observation and elementary rehabilitation (Working Party, 2010)

3.12: Ability to use neuropsychological formulations to assist multi-professional communication (Core Competencies in Clinical Psychology; ‘Psychological Formulation’, Dimension 3, Competency 3)

3.13: Ability to accommodate medical information from various sources (Consultation Process, 2012).
**Dimension Four: Personal and Professional Practice**

**A. Generic Clinical Skills**

4.1: Ability to understand ethical issues and apply this knowledge in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 1).

4.2: Ability to manage own personal learning needs and develop strategies for meeting these needs (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 6).

4.3: Ability to appreciate the power imbalance between practitioners and clients and how abuse of this can be minimised (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 2).

4.4: Ability to understand the impact and implications of differences, diversity and social inequalities on people’s lives and their implications for working practice (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 3). This includes Understanding the process of communicating effectively through interpreters and having an awareness of the limitations thereof (Core Competencies in Clinical Psychology; ‘Communicating and teaching’ Dimension 8, Competency 6).

4.5: Ability to understand the impact of one’s own value base, attitudes and behaviour on clinical practice and service users (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 4; adapted after Consultation Process, 2012).

4.6: Ability to use supervision to reflect on practice, and make appropriate use of feedback received (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 7).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

This includes the ability to use available expertise and advice from senior colleagues to support on-going professional development.

4.7: Ability to develop strategies to handle the emotional and physical impact of own practice and to seek appropriate support when necessary, with good awareness of boundary issues (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 8).

4.8: Ability to work collaboratively and constructively with fellow psychologists, other colleagues and users of services (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 9).

4.9: Ability to monitor and maintain the health, safety, and security (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 10).

4.10: Ability to work effectively at an appropriate level of autonomy, with awareness of the limits of one’s own competence, and accepting accountability to relevant professional and service managers (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 6).

[Click here to return to the competency map]
4.11: Ability to exercise duty of care with regard to safeguarding vulnerable groups (Expert Reference Group, 2011; Consultation Process, 2012).

4.12: Awareness of the legislative and national planning context of service delivery and clinical practice (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 5).

B: Neuropsychological Competencies

4.13: Knowledge of formal documents/guidelines in relation to ethical principles of practice, legal and statutory obligations and general professional standards as applied to practice in clinical neuropsychology (QiCN Candidate Handbook, Appendix 1, pp 29).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

This includes applied knowledge of general key guidelines and legislation: -

- Mental Capacity Act/ Adults with Incapacity (Scotland)
- Knowledge of driving guidelines and DVLA procedures
- Mental Health Act
- Protection of Vulnerable Adults
- Deprivation of Liberty Safeguards
- Safeguarding Children
- NICE guidelines/ Scottish Intercollegiate Guidelines Network (SIGN)

Practitioners must also have knowledge of specific guidelines and policies related to people with acquired brain injury/neurological conditions. For example,

- National Service Framework for people with long term conditions
- National Guidelines for Stroke
- Intelligent Targets for Dementia in Wales

4.14: Knowledge of the political and organisational context of health care delivery as it relates to neuropsychological clients, as well as relevant aspects of NHS and Social Services procedures, including arrangements for community care, support for neurological disability, and care for people who lack capacity (QiCN Candidate Handbook, Appendix 1, pp 29).

4.15: Knowledge of the differing requirements for neuropsychology in a range of contexts including private practice (Consultation Process, 2012)

Including knowledge of the differing requirements for neuropsychological reports in a range of contexts including medico-legal settings (QiCN Candidate Handbook, Appendix 1, pp 29).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

For example, practitioners undertaking private work should have an understanding of giving evidence in court, testamentary capacity, legal issues impinging on reports, duty of care etc

4.16: Knowledge of general professional issues, and developments in professional arrangements and practice both within a national and an international context, as well as an appreciation in general terms of certain practices and concerns of those professions most closely allied to clinical neuropsychology (QiCN Candidate Handbook, Appendix 1, pp 29).
A. Generic Clinical Skills

1.1: Ability to critically review and clinically apply research evidence (Core Competencies in Clinical Psychology; Research Dimension 6, Competency 1; QiCN Practitioner Handbook, Appendix 3, Guidelines on Clinical Psychology Research).

Competency 1.1 includes the following:

- Identify, review and critically appraise a substantial body of research evidence which is at the forefront of clinical psychology practice (Core Competencies in Clinical Psychology; Research Dimension 6, Competency 1).
- Identify, critically appraise and apply research evidence relevant to practice (Competencies in Educational Psychology, ‘Core Professional Skills’ Dimension 1, Competency 8).
- Demonstrate knowledge of neuropsychological constructs and neuropsychological theory as applied to clinical practice (QiCN Practitioner Handbook, Appendix 3, Guidelines on Clinical Psychology Research).

1.2: Ability to and carry out research, service evaluations and audit (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 2, 3, 4, 5, 6, 7 and Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 2).

Competency 1.2 includes the following:

- Understand applicable techniques for clinical research and advanced academic enquiry, including quantitative and qualitative approaches (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 2; Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry, Dimension 4, Competency 4).
- Develop a critical understanding of the philosophy of research, including alternative epistemological positions to provide a context for theory construction (Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry, Dimension 4, Competency 2).
- Conduct service evaluation and small N research (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 3).
- Conduct collaborative research (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 4).
- Work with key role partners to support the design, implementation, conduct, evaluation and dissemination of research activities, and to support local authorities in conducting robust evidence based research (Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry, Dimension 4, Competency 7).
- Conceptualise, design and conduct independent, original research of a quality to satisfy peer review, extend the forefront of the discipline, and merit publication: including identifying research questions, demonstrating an understanding of ethical issues, choosing appropriate research methods and analysis, reporting outcomes and identifying appropriate pathways for dissemination (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 5; Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry, Dimension 4, Competency 1).
- Understand the need and value of undertaking clinical research and development post-qualification, contributing substantially to the development of theory and practice in clinical psychology (Core Competencies in Clinical Psychology; ‘Research’ Dimension 6, Competency 6).
Develop a critical understanding of specialist/advanced methods relevant to the individual’s own research (Competency 5; Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry, Dimension 4, Competency 5).

Audit clinical effectiveness (Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 2).

1.3: Ability to listen and to demonstrate self-awareness and sensitivity, and working as a reflective practitioner (Core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 3; Competencies in Educational Psychology, ‘Core Professional Skills, Dimension 1, Competency 4).

1.4: Ability to think critically, reflectively and evaluatively (Core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 4; Competencies in Educational Psychology, ‘Core Professional Skills’ Dimension 1, Competency 4) and work as a reflective scientist-practitioner (edited by expert reference group, 2011)

1.5: Ability to work effectively whilst holding in mind alternative, competing explanations (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 5) and from the bio-psycho social spectrum (edited by expert reference group, 2011)

1.6: Ability to make [informed] judgements on complex issues in specialist fields, often in the absence of complete information (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 5; word ‘informed’ removed by expert reference group, 2011)

1.7: Ability to exercise personal responsibility and largely autonomous initiative in complex and unpredictable situations [in professional practice] (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 7; ‘in professional practice’ removed by expert reference group)

Competency 1.7 includes the ability to work effectively at an appropriate level of autonomy, with awareness of the limits of own competence, and accepting accountability to relevant professional, academic and service managers (Competencies in Educational Psychology, ‘Personal and professional standards and values’ Dimension 3, Competency 6).

1.8: Ability to generalise and synthesise prior knowledge and experience in order to apply critically and creatively in different settings and novel situations (core Competencies in Clinical Psychology; ‘Transferrable Skills’ Dimension 1, Competency 2 and Core Competencies in Educational Psychology, ‘Core Professional Skills’, Dimension 2, Competency 2).

1.9: Understanding of the supervision process for supervisee and supervisor roles (core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 4) and provide supervision at an appropriate level within own sphere of competence (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 1).

Including the ability to engage in and learn from supervision (Core Competencies in Educational Psychology; ‘Personal and professional standards and values’ Dimension 3, Competency 8).

1.10: Understanding of relevant psychological theory (QICN handbook, appendix 1 pp 25).

Relevant psychological theory includes knowledge of biological psychology, developmental psychology, attachment theory, human performance, health psychology, behavioural psychology, disability issues and adjustment models. Practitioners must also possess detailed knowledge of current models of normal cognitive function to facilitate an understanding of the approaches, models and findings of cognitive neuropsychology, together with their clinical implications.
1.11: Understanding of theories and models of leadership and change processes, and their application to service development and delivery (core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 4 and 9).

B. Neuropsychological Competencies

1.12: Understand the historical and theoretical foundations of developmental cognitive neuroscience, including early neural development, basic functional neuroanatomy, basic neurochemistry and psychopharmacology and basic neurobiology and genetics (QiCN Candidate Handbook, Appendix 2, pp 30).

1.13: Understanding of the terminologies methodologies and paradigms relevant to the study of developmental brain/behaviour relationships (QiCN Candidate Handbook, Appendix 2, pp 30).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Such techniques may include:
- Neuroimaging
- electrophysiology
- quantitative structural and functional neuroimaging
- quantitative electrophysiology including event related paradigms
- experimental cognitive techniques
- molecular genetic engineering techniques

Practitioners must understand the basic principles underlying a range of common techniques used to study the development of brain/behaviour relationships. Practitioners should also understand the current techniques that are most relevant to advancing contemporary clinical research within paediatric neuropsychology. Leading edge techniques are likely to come from the combination of advances within the fields of neuroimaging, electrophysiology, experimental cognitive neuropsychology and behavioural studies of animals following lesions or genetic manipulation. Practitioners should be able to critically evaluate the application of such techniques to inform clinical practice.

For example, practitioners must have a critical applied understanding of cognitive neuroscience techniques using behavioural and electrophysiological methods to assess timing and emergent organisation of very early cognitive skills with experimental paradigms such as visual paired comparisons, deferred imitation, infant search and habituation, Event Related Potential (ERP) paradigms.

Practitioners should be able to consider the links between genetics and brain development and have an understanding of the behavioural and cognitive functions throughout development.

1.14: Understand the major theories of brain/behaviour development and how they inform approaches to neuropsychological assessment and interpretation of data (QiCN Candidate Handbook, Appendix 2, pp 30).

Developmental cognitive neuroscience provides the scientific knowledge underpinning contemporary paediatric neuropsychology practice. In order to study the complex multifaceted development of human cognition and its neural underpinnings, it is essential that scientists in traditionally distinct fields integrate their methodologies. Practitioners should understand the historical, theoretical and methodological foundations of developmental cognitive neuroscience.

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1.15: Understand the neuroanatomical development of each sensory, motor and cognitive neural system and the integration of systems (QiCN Candidate Handbook, Appendix 2, pp 31).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Practitioners should understand key concepts of developmental processes, synaptic transmission and neuroanatomical organisation in the sensory systems including:
- vision
- audition
- somatosensory/pain
- motor systems
- integration of sensory systems

Practitioners should have an understanding of neural cognitive systems and emergent cognitive skills including:
- visual cognition
- language
- memory
- movement and motor planning
- attention/executive function
- social and emotional processing
- literacy, numeracy and written formulation

1.16: Understand major theories of normal cognitive learning and brain development (QiCN Candidate Handbook, Appendix 2, pp 31).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Major theories may include those of Piaget, Hebb and Luria.

1.17: Understand the competing processes involved in restoration after early injury or abnormal compensation within each neural-cognitive or motor system at different stages of development (QiCN Candidate Handbook, Appendix 2, pp 31).

Practitioners should understand the normal neuroanatomical development of each sensory, motor and cognitive neural system and the integration between systems. Practitioners should understand the competing processes involved in restoration after early injury or abnormal compensation within each neural-cognitive or motor system at different stages of development. Practitioners should understand the principles of neural plasticity and reorganisation of function following injury, for example, potential crowding and sleeper effects (London PgDip/MSc Learning Objectives in Clinical Paediatric Neuropsychology).

1.18: Understand the relationship between underlying neuropathology and cognitive outcome (London PgDip/MSc Learning Objectives in Clinical Paediatric Neuropsychology).

Practitioners should understand how neuropsychological outcome is shaped by aetiological factors and the underlying neuropathology in a range of developmental and acquired brain disorders (London PgDip/MSc Learning Objectives in Clinical Paediatric Neuropsychology). For example, Practitioners should understand the latest findings in neuropsychological outcome following neurosurgical treatment, particularly for the relief of intractable epilepsy.
1.19: Understand psychometric and statistical principles *(Expert Reference Group, 2011)*

*(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)*

Knowledge of psychometric principles may include the following:
- Understanding the purpose of expressing test scores using a common metric
- Understanding the most commonly used standard metrics (z scores, T scores, Standard Wechsler scores, IQ scores, Sten scores, Percentile Ranks)
- Understanding the meaning and limitations of age-equivalent scores
- Understanding the distinction between absolute levels of functioning and scores referenced to age norms.
- Understanding how to convert scores on one metric to another
- Understanding the concept of standard error of measurement and how it is calculated
- Understanding how one can determine whether test scores are reliably different
- Understanding of the processes for distinguishing normal and abnormal trajectories of cognitive development
- Understanding the importance of the distinction between the reliability and abnormality of test score differences
- Understanding the base rate issue when multiple tests are employed
- Understanding the factors influencing attempts to measure change in test performance
- Understanding the use of regression in measuring change in the individual case (including interpretation of change in test scores taken at different chronological ages)
- Understanding of the relative value of different sources of validity information in diagnostic testing
- Understanding the sensitivity and specificity of tests
- Understanding the role of base rates and the use of bayes theorem in diagnostic testing

*(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology; Expert Reference Group, 2011)*

1.20: Understand contemporary models/frameworks of health, disability and participation *(Expert Reference Group, 2011).*

*(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)*

Practitioners must be familiar with key frameworks of health, disability and participation for example, the International Classification of Functioning, Disability and Health [ICF], *(World Health Organisation, 2001)*

Practitioners must understand the legislative context for providing educational support for children in state schools (e.g. special educational needs and disability act, SENDIST)

1.21: Understand all aspects of common neuropsychological, neurological and neuropsychiatric conditions *(QiCN Candidate Handbook, Appendix 2, 30-31).*

*(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)*

Examples of common neuropsychological disorders may include:
- visual and perceptual disorders (e.g. agnosia, prosopagnosia)
- language and motor speech disorders (e.g. expressive/receptive dysphasia, verbal dyspraxia, dysarthria)
- memory disorders (e.g. material-specific deficits, amnesia)
- movement and motor planning disorders (e.g. dyspraxia, chorea)
- attention disorders (e.g. neglect)
- executive function disorders (e.g. action monitoring, impulse control, planning, perseveration)
- social and emotional processing disorders (e.g. social communication disorders, affective disorders, panic and anxiety disorders)
- literacy, numeracy and writing disorders (e.g. deep and surface dyslexia, dyscalculia, dysgraphia).

*Click here to return to the competency map*
Examples of common neuropsychological disorders may include:
- epilepsy syndromes and surgical interventions
- hydrocephalus
- brain tumours
- cerebrovascular disorders
- neuromuscular disorders
- movement disorders
- neurometabolic disorders
- traumatic brain injury

Examples of common neurodevelopmental disorders may include:
- specific language impairment,
- non-verbal learning difficulties
- attention deficit disorders
- autistic spectrum disorders

Examples of common neurodevelopmental disorders may include:
- anxiety
- depression
- childhood schizophrenia.


Practitioners should have knowledge of the specialised assessment and support strategies for infants and children at risk of developmental delay who may require early neurodevelopmental assessment. The principles and practice of clinical neurodevelopmental assessment batteries that measure sequential neurodevelopmental steps in early cognitive, language and motor development should be understood and how these compare to the measurements of cognitive dissociations in neuropsychological assessment. Practitioners should also understand how experimental applications such as Event Related Potentials and visual paired comparisons are used to assess attention, timing and organisation of very early cognitive skills in infants.
DIMENSION TWO: CLINICAL WORK

A. Generic Clinical Skills

2.1: Ability to develop and sustain professional relationships as an independent practitioner (Core Competencies in Clinical Psychology; ‘Psychological Assessment’ Dimension 9, Competency 8; Working Party, 2011).

Competency 2.1 includes:
- Develop and maintain effective working relationships with key role partners including: children, young people, their carers, teachers and other professionals. Work collaboratively, when appropriate, with the above role partners to promote effective outcomes for clients (Competencies in Educational Psychology, ‘Core Professional Skills’ Dimension 1, Competency 6).
- Developing and maintaining effective working alliances with clients, including individuals, carers and services (Core Competencies in Clinical Psychology; ‘Psychological Assessment’ Dimension 9, Competency 8).
- Developing and sustaining relationships with team members, fellow psychologists, other health professionals and organisations (Expert Reference Group, 2011)

2.2: Ability to work effectively in multi-disciplinary teams (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 8) and contribute a distinct psychological perspective within multi-disciplinary teams (‘Core Competencies in Education Psychology, ‘Practice of Applied Educational Psychology’ Dimension 2, Competency 10).

2.3: Ability to work effectively with formal service systems and procedures (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 6).

2.4: Ability to adapt practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 6).

2.5: Ability to bring about change for individuals, children, young people and their families by working at different levels [e.g. individuals, families, groups, communities, organisations, local authorities and national priorities] (Competencies in Educational Psychology, ‘Practice of Applied Educational Psychologists’ Dimension 2, Competency 3).

Including the ability to work systemically in different contexts and settings (Expert Reference Group, 2011)

2.6: Ability to engage children, young people and their carers as active participants in assessment and decision-making processes, and in the evaluation of interventions and service delivery (Competencies in Educational Psychology, ‘Practice of Applied Educational Psychologists’ Dimension 2, Competency 7).

2.7: Ability to choose, use and interpret a broad range of assessment methods appropriate to the client and service delivery system in which the assessment takes place and to the type of intervention which is likely to be required (Core Competencies in Clinical Psychology; ‘Psychological Assessment’, Dimension 2, Competency 2; Competencies in Educational Psychology, ‘Practice of Apllied Educational Psychologists’ Dimension 2, Competency 4).
Including: -

- formal procedures (use of standardised psychometric instruments)
- systematic interviewing procedures
- other structured methods of assessment (e.g. observation, or gathering information from others)
- understanding the relevance of behavioural assessment or observation in multiple contexts e.g. clinic, home and school.
- assessment of social context and organisation
- understanding typical biases affecting parental and teacher reports and the factors which may influence the validity and reliability of third party reports

2.8: Ability to decide, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with children, young people, families, carers and service systems (Core Competencies in Clinical Psychology; ‘Transferable Skills’ Dimension 1, Competency 1; Core Competencies in Educational Psychology; ‘Core Professional Skills’ Dimension 1, Competency 1; NB – ‘children’, ‘young people’ and ‘families’ added).

2.9: Ability to develop formulations which integrate information from assessments within a coherent framework that draws upon psychological and neuropsychological theory (Core Competencies in Clinical Psychology; ‘Psychological Formulation’ Dimension 3, Competency 1).

2.10: Ability to direct, co-ordinate, support or facilitate teams together with an understanding of the principles of operation within a multidisciplinary or management team (QiCN Practitioner Handbook, Appendix 1, pp 29)

2.11: Ability to recognise when (further) intervention is inappropriate, or unlikely to be helpful, and communicating this sensitively (Core Competencies in Clinical Psychology; ‘Psychological Intervention’ Dimension 4, Competency 7).

2.12: Ability to select and implement appropriate methods to evaluate the effectiveness, acceptability and broader impact of interventions at a service and organisational level, and using this information to shape practice and develop services. Where appropriate this will also involve devising innovative procedures (Core Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry’, Dimension 4, Competency 3; Core Competencies in Clinical Psychology; ‘Evaluation’ Dimension 5, Competency 1; ‘at a service and organisation level added by working party, 2011, Consultation Process, 2012).

Including the ability to: -

- formulate interventions that focus on applying knowledge, skills and expertise to support identified local and national initiatives (Core Competencies in Educational Psychology; ‘Practice of applied educational psychologists’ Dimension 2, Competency 5).

2.13: Knowledge of factors which must be considered in selecting an intervention and knowledge of barriers to intervention (QiCN Practitioner Handbook, Appendix 1, pp28-29)

Including the ability to: -

- apply, review and evaluate a range of professionally appropriate counselling and therapeutic skills in work with children, their families and other professionals (Core Competencies in Educational Psychology; ‘Practice of applied educational psychologists’ Dimension 2, Competency 5).
2.14: Knowledge of procedures by which the progress of and outcomes from an intervention may be assessed at the client level [individuals, groups and families] (QICN Practitioner Handbook, Appendix 1, pp 28-29; Core Competencies in Educational Psychology, ‘Application of evaluation, research and enquiry’, Dimension 4, Competency 3).

Including the ability to:

- develop and apply practice based on evidence-based approaches, incorporating evaluation, monitoring and review of outcomes (Core Competencies in Educational Psychology; ‘Practice of applied educational psychologists’ Dimension 2, Competency 6).

B. Neuropsychological Competencies

General Competencies

2.15: Ability to demonstrate a holistic understanding of the social, psychological, cognitive and educational impact of acquired brain injury and neurological conditions both for children/young people and systems (Expert Reference Group, 2011, Consultation Process, 2012).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Specific example of knowledge in this area may include understanding:

- the prevalence and diagnosis of childhood behaviour problems which can emerge after acquired brain injury/ neurological impairment
- the range of factors including systemic, emotional and cognitive, that may contribute to the emergence of behaviour problems after acquired brain injury or neurological impairment
- how to assess problems of anger and aggression and emotional consequences of childhood acquired brain injury or neurological impairment
- the evidence base relating to the efficacy, the main approaches to the management of emotional and behavioural disturbance following acquired brain injury or neurological impairment (anger and aggression) including pharmacological, psychological therapy and behaviour management approaches.
- the most common psychosocial consequences of acquired brain injury or neurological impairment including changes in behaviour, personality and psychiatric disorders.
- Common family, educational and other systemic difficulties which may arise following childhood acquired brain injury or neurological impairment
- The impact of acquired brain injury/neurological conditions on family functioning, personal, educational and social relationships and community participation

2.16: Ability to identify cognitive impairment, behavioural changes and emotional difficulties and provide integrated psychological/neuropsychological approaches to manage these (Expert Reference Group, 2011).

Neuropsychological assessment

2.17: Ability to tailor neuropsychological assessment to individuals and to address appropriate questions (Expert Reference Group, 2011)
2.18: Ability to understand neuropsychological assessment including the psychometric principles of neuropsychological assessment and the measurement of cognitive change during development (QiCN Candidate Handbook, Appendix 2, pp 32).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Understanding Neuropsychological Assessment
Practitioners must understand the underpinning principles of neuropsychological assessment in children and adolescents and the many variables involved in the administration, interpretation and reporting of neuropsychological assessments. Paediatric clinical neuropsychologists are required to diagnose functions that are at risk of compromise and provide prognosis of outcome after brain injury/disease at different stages of development. Therefore, all assessment procedures should build on key concepts of normal and abnormal brain development. Practitioners need to know the strengths and weaknesses of various tests used for assessing different components of cognition and behaviour and how to evaluate new tests as they are developed. Practitioners are required to understand the importance of interpreting tests within the context of individual cases and describing potential functional implications (Learning Objectives, London PgDip/MSc course in Clinical Paediatric Neuropsychology).

Practitioners must have a critical understanding of clinical assessment techniques using commercially available neurodevelopmental batteries.

Practitioners should have an applied understanding of the specialised assessment and support strategies for infants and children at risk of developmental delay who require early neurodevelopmental assessment.

Practitioners should understand the principles and practice of clinical neurodevelopmental assessment batteries that measure sequential neurodevelopmental steps in early cognitive, language and motor development and how these compare to the measurements of cognitive dissociations in neuropsychological assessment.

Practitioners should have knowledge of the specialised assessment and support strategies for infants and children at risk of developmental delay who may require early neurodevelopmental assessment. The principles and practice of clinical neurodevelopmental assessment batteries that measure sequential neurodevelopmental steps in early cognitive, language and motor development should be understood and how these compare to the measurements of cognitive dissociations in neuropsychological assessment. Practitioners should also understand how experimental applications such as Event Related Potentials and visual paired comparisons are used to assess attention, timing and organisation of very early cognitive skills in infants.

(Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology)

Understanding Psychometric Principles in relation to neuropsychological assessment
Practitioners must have a thorough and comprehensive knowledge of the assessment procedures adopted in clinical neuropsychology. They should already possess a sound knowledge of psychometric and statistical principles (see competency 1.20) and must in addition be familiar with an adequate range of the assessment instruments employed in general paediatric neuropsychological practice. Practitioners should be able to evaluate the strengths and weaknesses of new test batteries as they are developed (QiCN Candidate Handbook, Appendix 1, pp 26; QiCN Candidate Handbook, Appendix 2, pp 32).
For example, knowledge of the psychometric principles underpinning the selection, administration and interpretation of cognitive tests scores may include:

- Understanding of test manuals and other published data in order to critically appraise the psychometric properties of commonly used neuropsychological tests
- Appreciating the strengths and limitations of a range of commonly used cognitive tests
- Understanding the concept of reliability/stability of neuropsychological tests and how these are determined
- Understanding the effects of age and IQ on reliability and validity of cognitive tests
- Understand the particular influence of engagement and comprehension of instructions and concepts on the validity of tests across the lifespan
- Understand the validity of cognitive constructs e.g. executive function, as applied to your children

2.19: Ability to understand neurodevelopmental assessment batteries and how these differ from neuropsychological measures (QiCN Candidate Handbook, Appendix 2, pp 32; (Learning Objectives, London PgDip/MSc course in Clinical Paediatric Neuropsychology).

2.20: Ability to understand how to integrate neuropsychological data with other measures of brain function to improve diagnosis and prognosis (Learning Objectives, London PgDip/MSc course in Clinical Paediatric Neuropsychology).

2.21: Ability to understand & administer the tools used to assess different components of cognition and behaviour and ability to evaluate new tools as they are developed (Learning Objectives, London PgDip/MSc course in Clinical Paediatric Neuropsychology).

Practitioners must provide evidence of a thorough and comprehensive knowledge of the assessment procedures adopted in paediatric clinical neuropsychology. They should already possess a sound knowledge of psychometric and statistical principles (see competency 1.18) and must in addition be familiar with an adequate range of the assessment instruments employed in general clinical neuropsychological practice. Practitioners must also show an understanding about the assessment of change over time and issues related to repeat assessment and monitoring progress.

2.22: Ability to understand the range of factors that affect a child/young person's performance on neuropsychological/neurodevelopmental tests (Expert reference Group, 2011).

Practitioners must understand the range of information over and above cognitive test results that should be obtained as part of a neuropsychological assessment (Learning Objectives, Glasgow PgDip/MSc course in Clinical Neuropsychology). For example this may include, medication, individual or family mental health difficulties, developmental history (social emotional and cognitive development), medical history (including birth trauma, physical health problems), educational history and attainment, family history, coping styles, bilingualism, cultural biases, diversity etc.

2.23: Ability to understand the expected neuropsychological profiles associated with a range of neurological, neurodevelopmental and neuropsychiatric disorders (QiCN Candidate Handbook, Appendix 2, pp 31-32).

Practitioners should understand how neuropsychological outcome is shaped by aetiological factors and the underlying neuropathology in a range of common developmental and acquired brain disorders (QiCN Candidate Handbook, Appendix 2, pp 32).

Neuropsychological formulation

2.24: Ability to produce neuropsychological formulations that reflect the complex range of variables involved in pediatric clinical cases (QiCN Candidate Handbook, Appendix 2, pp 32).

Includes the ability to formulate using different models include systemic models
2.25: Ability to use neuropsychological formulations to facilitate a child's or young person's understanding and adjustment of their experiences and to plan interventions, coupled with the ability to revise formulations (Expert Reference Group, 2011).

Neuropsychological intervention and rehabilitation

2.26: Ability to demonstrate applied understanding of neurological recovery and neuropsychological rehabilitation (Expert Reference Groups, 2011).

Practitioners must understand the developmental processes which underpin spontaneous recovery and reorganisation of functioning following childhood ABI. Practitioners must understand the limitation of developmental plasticity in relation to timing of brain injury in childhood. Practitioners must understand the influence of critical periods on the development of e.g. language functioning following acquired brain injury.

2.27: Ability to use formulation and to devise, deliver and evaluate evidence based psychological/neuropsychological interventions which are individually tailored to the child/young person/family (Expert Reference Group, 2011; Consultation Process, 2012).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

For example interventions may include:
- Psychological Interventions, for example, Cognitive Behavioural Therapy
- Neurorehabilitation including compensatory interventions according to cognitive systems, such as errorless learning
- Family or school based interventions to support learning or behavioural management
- Pharmacological interventions
- Behavioural interventions
- Potentially restorative interventions

2.28: Ability to adapt models of therapeutic intervention for psychological difficulty in the context of impaired cognitive functioning and developmental age (Expert Reference Group, 2011).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

For example in relation to brain injury and behavioural interventions, practitioners must be able to critically appraise the rationale for the application of a behavioural intervention in the context of brain injury with reference to integrative biopsychosocial models of the consequences of brain injury. Practitioners must be aware of the challenges to implementing intervention in the context of brain injury and understand the way in which interventions may be adapted to take account of deficits associated with brain injury. Practitioners must have a critical understanding of the evidence relating to the efficacy of a variety of interventions in the context of brain injury.

2.29: Ability to understand methods of reintegration into the educational system after acquired brain injury and work with support staff, teachers, parents and children to support this process (QiCN Candidate Handbook, Appendix 2, pp 32; Learning Objectives MSc London; Module 8, Developing clinical formulations and interventions).

2.30: Ability to understand the relationship between patterns of cognitive function and appropriate learning intervention (Expert Reference Group, 2011).

2.31: Ability to understand the relationship between cognitive impairment and educational progress and attainment (Expert Reference Group, 2011).

Click here to return to the competency map
2.32: Ability to understand treatment approaches and management for a range of common developmental and acquired neuropsychological/neurological conditions (QiCN Candidate Handbook, Appendix 2, pp 32).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

For example, practitioners should understand the latest findings in neuropsychological outcome following neurosurgical treatment, particularly for the relief of intractable epilepsy.

Practitioners must have a critical applied understanding of portage and early interventions.

Practitioners understand potential interventions for infants/children with developmental delay

2.33: Awareness of specialist settings for acute or long term support for children with neuropsychological difficulties (QiCN Candidate Handbook, Appendix 2, pp 33).

Practitioners must have an understanding of specialist and mainstream school provision and the accommodation of children with special educational needs in these settings. Practitioners should be aware of specialist schools supporting children with specific language, sensory or social communication or behavioural difficulties. Practitioners should understand mechanisms for delivery of education in hospital or YOI settings.

2.34: Understand the role of neuropsychology in child mental health services and in developing assessment, formulation and interventions (Consultation process, 2012)
A: Generic Clinical Skills

3.1: Ability to prepare and deliver teaching and training which takes into account the needs and goals of the participants (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 3).

3.2: Ability to demonstrate sound knowledge of the principles of report writing and other aspects of professional communication (QiCN Candidate Handbook, Appendix 1, pp 29).

   Includes: -
   - Demonstrate effective reporting and recording skills across a range of settings and activities (Core Competencies in Educational Psychology; ‘Core Professional Skills’, Dimension 1, Competency 12).

3.3: Ability to communicate psychologically-informed ideas and conclusions clearly and effectively to specialist and non-specialist audiences (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 3).

   Includes the ability to: -
   - Effectively communicate psychological knowledge and insights (Core Competencies in Educational Psychology; ‘Core Professional Skills’, Dimension 1, Competency 10).
   - Demonstrate effective interpersonal communication skills across a range of settings and activities (Core Competencies in Educational Psychology; ‘Core Professional Skills’, Dimension 1, Competency 11).

3.4: Ability to demonstrate understanding of consultancy models and the contribution of consultancy to practice (Core Competencies in Clinical Psychology; ‘Service Delivery, Dimension 9, Competency 3; Core Competencies in Educational Psychology; ‘Practice of applied educational psychologists’, Dimension 2, Competency 9).

B: Neuropsychological Competencies

3.5: Ability to communicate effectively with children and young people (Expert Reference Group, 2011).

3.6: Ability to adapt style of communication to children and young people of different developmental ages with a wide range of neuropsychological disorders and differing levels of cognitive ability, sensory acuity and modes of communication (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 2).

3.7: Ability to adapt communication and level of detail used in communication depending on the audience (Expert Reference Group, 2011). Competency 3.7 includes the ability to: - Communicate clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences [for example, to professional colleagues, and to service users and their carers] (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 1).

Click here to return to the competency map
For example, the ability to adapt and simplify reading materials for children and young people (Consultation Process, 2012)

3.8: Ability to communicate effectively clinical and non-clinical information from a neuropsychological perspective in a style appropriate to a variety of different audiences (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 1).

3.9: Ability to understand the process of providing expert neuropsychological opinion and advice, including the preparation and presentation of evidence in formal settings (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 5 - modified to be specific to neuropsychology).

3.10: Ability to sensitively communicate neuropsychological results and formulations with professionals, parents and children as well as describing functional impairments (Learning Objectives, London PgDip/MSc course in Clinical Paediatric Neuropsychology; QICN Handbook, Appendix 2 pp 32 – ‘formulation added’).

3.11: Ability to support others’ learning in the application of neuropsychological skills, knowledge, practices and procedures (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 7).

3.12: Ability to use neuropsychological formulations to assist multi-professional communication and understanding (Core Competencies in Clinical Psychology; ‘Psychological Formulation’, Dimension 3, Competency 3).

3.13: Ability to understand the process of providing expert neuropsychological opinion and advice, including the preparation and presentation of evidence in formal settings (Core Competencies in Clinical Psychology; ‘Communication and Teaching’ Dimension 8, Competency 5 - modified to be specific to neuropsychology).

3.14: Ability to accommodate additional medical information from various sources when communication with other professionals, service users and their families/carers (Consultation Process, 2012)
A. Generic Clinical Skills

4.1: Understand potential ethical dilemmas within a range of professional contexts and describe appropriate pathways for working through such dilemmas (Learning Objectives MSc London; Module 2, Professional Issues for Paediatric Neuropsychologists).

Competency 4.2 includes the ability to understand ethical issues and apply this knowledge in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 1).

4.2: Ability to manage own personal learning needs and develop strategies for meeting these needs (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 6; Core Competencies in Educational Psychology, ‘Personal and profession standards and values’, Dimension 3, Competency 5).

4.3: Ability to appreciate the power imbalance between practitioners and clients and how abuse of this can be minimised (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 2).

4.4: Ability to understand the impact and implications of differences, diversity and social inequalities on people’s lives and their implications for working practice (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 3; Competencies in Educational Psychology, ‘Personal and professional standards and values’ Dimension 3, Competency 4).

Competency 4.5 includes the ability to understand the process of communicating effectively through interpreters and having an awareness of the limitations thereof (Core Competencies in Clinical Psychology; ‘Communicating and teaching’ Dimension 8, Competency 6).

4.5: Ability to understand the impact of one’s own value base, attitude and behaviour on clinical practice (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 4; Core Competencies in Educational Psychology, ‘Personal and profession standards and values’, Dimension 3, Competency 8) and service users (Consultation Process, 2012).

4.6: Ability to use supervision to reflect on practice, and make appropriate use of feedback received (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 7). Including the ability to use available expertise and advice from senior colleagues in order to support ongoing professional development (Consultation process, 2012).

4.7: Ability to develop strategies to handle the emotional and physical impact of own practice and to seek appropriate support when necessary, with good awareness of boundary issues (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 8).

4.8: Ability to work collaboratively and constructively with fellow psychologists, other colleagues and users of services (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 9).
4.9: Ability to monitor and maintain health, safety, and security (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 10).

4.10: Ability to work effectively at an appropriate level of autonomy, with awareness of the limits of one’s own competence, and accepting accountability to relevant professional and service managers (Core Competencies in Clinical Psychology; ‘Personal and Professional Skills and Values’ Dimension 7, Competency 6).

4.11: Exercise duty of care with regard to safeguarding children (Expert Reference Group, 2011; (Competencies in Educational Psychology, ‘Core Professional Skills’ Dimension1, Competency 5) and other vulnerable groups (Consultation Process, 2012).

4.12: Awareness of the legislative and national planning context of service delivery and clinical practice (Core Competencies in Clinical Psychology; ‘Service Delivery’ Dimension 9, Competency 5).

4.13: Ability to demonstrate effective professional management & organisational skills (Core Competencies in Educational Psychology; ‘Core Professional Skills, Dimension 1, Competency 9).

4.14: demonstrate professional and ethical practice which adheres to the British Psychological Society’s Code of Conduct (Core Competencies in Educational Psychology; ‘Core Professional Skills, Dimension 1, Competency 9).

Including the ability to:
Apply knowledge of, and demonstrate the ability to operate effectively within, the legal, national and local frameworks for educational/clinical psychology practice (Core Competencies in Educational Psychology; ‘Core Professional Skills, Dimension 1, Competency 9).

B: Neuropsychological Competencies

4.15: Understand differing roles of paediatric neuropsychology within a range of professional settings and how their work may overlap with multidisciplinary colleagues (Learning Objectives MSc London; Module 2, Professional Issues for Paediatric Neuropsychologists: QICN Handbook, Appendix 2 pp 33)

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

Practitioners must have an understanding of the different roles that paediatric clinical neuropsychologists perform when working within different professional contexts such as specialist neuroscience centres, child and adolescent mental health teams, educational systems, research programmes and medico-legal work (Learning Objectives MSc London; Module 2, Professional Issues for Paediatric Neuropsychologists)

Professional practice issues and context may include:-
- neuropsychology interface in clinical neuroscience settings
- multidisciplinary professional roles including neurology, neurosurgery, neuropsychiatry, speech and language therapy, occupational therapy, physiotherapy, specialist nurses
- neuropsychology interface with educational systems-professional issues in educational contexts
- neuropsychology interface with CAMHS-professional issues in mental health contexts
- issues for paediatric clinical neuropsychologists in medico-legal work
- issues for paediatric clinical neuropsychologists in forensic work
- ethical dilemmas for clinicians and academics in paediatric neuropsychology
- key areas in Educational Psychology practice for clinical psychologists
- key areas in Clinical Psychology practice for educational psychologists

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4.16: Understanding of health and educational policies that are relevant to children and young people who have developmental learning difficulties or acquired brain injuries (Learning Objectives MSc London; Module 8, Developing clinical formulations and interventions).

4.17: Knowledge of formal documents/guidelines in relation to ethical principles of practice, legal and statutory obligations and general professional standards as applied to clinical practice in neuropsychology (QiCN Candidate Handbook, Appendix 1, pp 29).

(NB: the following examples are intended as illustrations only and NOT as comprehensive lists)

This includes applied knowledge of general key guidelines and legislation: - for example mental health, mental capacity and educational legislation

- Gillick/Fraser competency (Expert Reference Group, 2011)
- Children Act 1989 and 2004
- Education for Persons with Special Educational Needs 2004
- Disability Act 2004
- Mental Health Act
- Deprivation of Liberty Safeguards
- NICE guidelines/ Scottish Intercollegiate Guidelines Network (SIGN)

Practitioners must also have knowledge of specific guidelines and policies related to people with acquired brain injury. For example,

- National Service Framework for long-term conditions
- Children’s NSF
- DFeS/DoH exemplar on management of childhood acquired brain injury

4.18: Knowledge of the political and organisational context of health care delivery as it relates to children and young people with neuropsychological difficulties, as well as relevant aspects of NHS, local governmental and Social Services procedures, including arrangements for community care, education, support for neurological disability (QiCN Candidate Handbook, Appendix 1, pp 29 – ‘children and young people added).

4.19: Knowledge of the differing requirements for neuropsychology in a range of contexts including private practice (Consultation Process, 2012)

Including knowledge of the differing requirements for neuropsychological reports in a range of contexts including medico-legal settings (QiCN Candidate Handbook, Appendix 1, pp 29).

For example, practitioners undertaking private work should have an understanding of giving evidence in court, legal issues impinging on reports, duty of care etc

4.20: Knowledge of general professional issues, and developments in professional arrangements and practice both within a national and an international context, as well as an appreciation in general terms of certain practices and concerns of those professions most closely allied to clinical paediatric neuropsychology (QiCN Candidate Handbook, Appendix 1, pp 29 – ‘paediatric added).