

**Naval Medical Center Portsmouth
MENTAL HEALTH DEPARTMENT
PSYCHOLOGY TRAINING PROGRAMS**

**CLINICAL PSYCHOLOGY INTERNSHIP
TRAINING PROGRAM**

PROGRAM MANUAL

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INTRODUCTION

The Mental Health Department at Naval Medical Center, Portsmouth, VA offers a predoctoral Internship Training Program in Clinical Psychology. The program is organized around a Practitioner-Scholar model and provides an intensive twelve-month in-service period of clinical and didactic experiences. Interns develop a wide range of professional competencies within the context of four training rotations (inpatient psychiatry, two in outpatient mental health, and a choice among health psychology, child/family psychology, or assessment). Additionally, they participate in a year-long Transrotational Evidence Based Therapy learning experience. The mission of the program is the development of generalist clinicians who emerge from the training program with foundational and functional competencies appropriate for entry into clinical practice and who subsequently embark on a path of life-long learning to assure ongoing development of professional skills. A unique aspect of the training experience is exposure to the practice of clinical psychology in operational settings—interns spend several days aboard a major Navy combatant vessel working with the ship’s psychologist, visit a Marine or Navy SEAL base where other psychologists practice, and receive an introduction to substance misuse treatment within a Navy treatment facility. The training year, combined with competencies developed through prior practicum experiences, provides the foundation needed for practice within the military mental health system yet is sufficiently broad to prepare the intern for practice in diverse non-military clinical settings. Furthermore, this program prepares the intern for eventual licensure as a psychologist in the state of his/her choosing, and is conducive to eventual attainment of Board Certification in clinical psychology. This program is partially affiliated with the Department of Medical and Clinical Psychology of the Uniformed Services University of the Health Sciences, Bethesda, Maryland, and accepts applications from this program on a yearly basis. Other applicants are limited to persons whose graduate studies, or respecialization activities, have been financially supported by the Navy within an APA-accredited graduate school.

This Internship Training Program is accredited by the American Psychological Association (APA). Inquiries regarding accreditation may be addressed to the American Psychological Association’s Commission on Accreditation at the following address or phone number:

Office of Program Consultation and Accreditation

American Psychological Association

750 First Street, N.E.

Washington, D.C., 20002-4242

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THE NAVAL MEDICAL CENTER PORTSMOUTH

The Naval Medical Center, Portsmouth, Virginia (NMCP) is situated beside the Elizabeth River, near downtown Portsmouth, across the river from the city of Norfolk, and not far from the largest naval base in the world. The hospital buildings on the compound are predominant landmarks on the Portsmouth waterfront. One is a high rise structure that was built in the early sixties but extensively renovated within the past 7 years and houses various outpatient clinics, including clinics operated by the Mental Health Department. Adjacent to this structure is the Charrette Health Center, which was completed and occupied in 1999. This 330 million-dollar, five story, one million square foot structure is a state of the art hospital, and its completion made the Naval Medical Center at Portsmouth the largest medical treatment facility in the Navy. A short distance away situated on "Admiral's Point" is the original hospital building, dating from 1827 and distinguished as the first Naval Hospital in the United States. The original hospital provided continuous health care from 1830 to 1999, when it became a historical monument and administrative building. The buildings around the hospital house enlisted staff living quarters, a Navy exchange, an indoor swimming pool, a superb gym, a parking garage, a consolidated club (i.e., a club shared by officers and enlisted service members), and various other support services. In addition to the core hospital, there are 11 branch medical clinics in the Naval Medical Center Command, which are located in reasonable proximity to the main hospital complex.

The Medical Center is a major teaching facility with fourteen accredited medical residency programs serving over 250 physicians in training. Training programs are also offered for Nurses, Physician Assistants, Radiology technicians and other allied health professions. It is affiliated with the Eastern Virginia Medical School, which has its main campus in Norfolk. Both the Medical School and Old Dominion University, also located in Norfolk, are close by making the advantages of being near university graduate level education in both general and health care fields available as well. An additional affiliation is with the Veterans Affairs Medical Center located in Hampton, VA. As part of its commitment to health care education, the Mental Health Department's Psychology Internship Training Program has the full financial support of the Department of the Navy.

Naval Medical Center Portsmouth is the principal defense health care resource serving the Atlantic area. The foremost missions of the medical center are to provide health care to its beneficiaries, train its personnel to meet operational commitments worldwide, and conduct basic and advanced educational programs for the professional development of its staff. Additionally it advocates for the prevention of injury and illness, and promotes fitness and wellbeing through the awareness of healthy lifestyles. It exists to keep active duty military members fit to fight and to care for them when they are injured or ill. It ensures comprehensive care for their families and others entrusted to its care. Its beneficiaries range in age from the newborn to the elderly and come from a wide range of socioeconomic, ethnic and racial backgrounds. The clinical issues that are common to any large teaching hospital are available for teaching purposes. Additionally, the distinctive issues that are relevant to military medicine receive an emphasis that brings the practitioner in training to a high state of readiness for his or her next assignment. In brief, NMCP offers a rich clinical training environment plus a sincere commitment to the training of diverse health care professionals.

MENTAL HEALTH DEPARTMENT, NMCP

The Mental Health Department is administratively housed within the Medical Center's Mental Health Directorate along with the Warrior Recovery Center (housing specialized traumatic brain injury and post-traumatic-stress disorder programs) and the Substance Abuse Rehabilitation Program. In concert with the medical center's missions, the Mental Health Department provides direct patient care, prepares its staff for operational contingencies, is an APA approved sponsor of continuing education for psychologists, and operates an APA accredited Postdoctoral Fellowship program in addition to the internship. Staff consists of uniformed (Navy, United States Public Health Service) and civilian psychologists, psychiatrists, social workers, and psychiatric nurse practitioners. Currently, there are thirteen uniformed and seven civilian doctoral level clinical psychologists providing services in general outpatient mental health clinics and in subspecialty clinics in health psychology, orthopedic pain psychology, child/family psychology, and neuropsychology/psychological assessment. Support personnel include active duty psychiatry technicians, civilian psychology technicians, nurse case managers, several office clerks, an office manager/administrative assistant, and a training administrative assistant.

The majority of the Mental Health Department psychologists work at the core hospital in Portsmouth, and interns spend the training year there with the exception of the rotation at the Naval Air Station Oceana Clinic. Several staff psychologists work in clinics located in several localities close to the main medical center. The Mental Health Department has appropriate offices/work spaces for interns, up-to-date computers, digital recorders, and other technological resources to carry out its mission. The upgrading of technology is a continuous process.

Internship Training Program Description

Goals and Objectives: NMCP's Clinical Psychology Internship Training Program follows a Practitioner-Scholar training model designed to develop "generalist" clinicians capable of functioning in diverse treatment settings. Interns complete four training rotations (inpatient psychiatry, 2 in outpatient mental health, and a choice among health psychology, child/family psychology, and assessment). Additionally, they participate in a year-long Transrotational Evidence Based Therapy learning experience. Training encompasses assessment, intervention, consultation, and interdisciplinary team experiences, as well as other competencies expected of a professional psychologist entering practice. An emphasis on evidence-based practice permeates the training program, along with the immersion of ethics and diversity issues into the day-to-day activities of the intern. The program has three primary objectives: 1.) the development of professional competency at the developmental level of readiness for entry to practice; 2.) the preparation of the intern for a career of life-long learning as a psychologist; and 3.) the development and maintenance of a high quality training program as signified by maintenance of its APA accreditation status.

Every aspect of our training model is informed by the notion of professional competence. Training objectives and assessments of intern performance throughout the training year and at its conclusion are delineated according to specific competency benchmarks. Benchmarks used in this program come directly from the work of Fouad and colleagues (Fouad, Grus, Hatcher, Kaslow, Hutchings, Madison, Collins, & Crossman, 2009) as presented in their paper entitled

Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels, and our assessment instruments parallel those recommended in the accompanying article, *Competency Assessment Toolkit for Professional Psychology* (Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfa, 2009). Though training in accordance with these benchmarks and assessment instruments is not mandated by official policy of the APA, we believe these published resources offer the best available guidance regarding the conceptualization and assessment of competence for the emerging psychological provider. Core competency domains are arranged according to seven Foundational competencies (i.e., Professionalism; Reflective practice/Self-assessment/Self-care; Scientific Knowledge and Methods; Relationships, Individual and Cultural Diversity; Ethical Legal Standards and Policy; and Interdisciplinary systems) and eight Functional competencies (i.e., Assessment; Intervention; Consultation; Research/evaluation; Supervision; Teaching; Management-administration; and Advocacy). The available benchmarks span three developmental levels—Readiness for Practicum, Readiness for Internship, and Readiness for Entry to Practice.

In order to apply this model to both of our training programs (i.e., Postdoctoral Fellowship and Internship), we have extended developmental levels to include two additional categories—Readiness for Fully Autonomous Practice and Readiness for Life-long Learning. Specific criteria (i.e., benchmarks) for these developmental levels were formed by NMCP psychologists by making logical extensions of criteria provided in the published Benchmarks Document. These expanded benchmarks, in digital form or in a printed manual, are available from the Psychology Training Director upon request. Additionally, to facilitate communication of developmental levels and to make them more reflective of fine-grained developmental changes, we have made the assumption that developmental stages are continuous and can be subdivided into intermediate levels separating the major stages.

We have chosen to describe placement along the developmental continuum with a numerical system, as follows:

- 1.00 Meets criteria for Readiness for Practicum
- 1.25 Mildly exceeds some criteria for Readiness for Practicum
- 1.50 Mid-way between Readiness for Practicum and Readiness for Internship
- 1.75 Approaches or meets some criteria for Readiness for Internship
- 2.0 Meets criteria for Readiness for Internship
- 2.25 Mildly exceeds some criteria for Readiness for Internship
- 2.50 Mid-way between Readiness for Internship and Readiness for Entry to Practice
- 2.75 Approaches or meets some criteria for Readiness for Entry to Practice
- 3.00 Meets criteria for Readiness for Entry to Practice

- 3.25 Mildly exceeds some criteria for Readiness for Entry to Practice
- 3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice
- 3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice
- 4.00 Meets criteria for Readiness for Fully Autonomous Practice
- 4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice
- 4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning
- 4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning
- 5.00 Meets criteria for Entry to Life-long Learning/Master Clinician

It is important to note that assignment of developmental levels per the above numerical scale is based on supervisor judgment. We are not implying that this is a psychometrically precise measurement scale. Supervisors must compare the descriptively anchored, benchmarked standards against data obtained through direct observation of trainee activities, informed by other data sources (e.g., ratings made by interdisciplinary team members, outcome data for patients seen by trainees, objective tests covering reading assignments, review of audio/video tapes of clinical activities), and render a developmentally-anchored conclusion regarding trainee competence. We believe that our criterion-referenced scale has sufficient ordinal, and possibly interval, properties to permit the use of descriptive statistics and, accordingly, we use mathematical averages to summarize judgments offered by multiple supervisors and to average across differing sets of discrete competencies. Analyses performed to date regarding inter-rater agreement among supervisors have been encouraging with findings indicating that a minimum of two raters are needed to obtain reasonably reliable ratings of competency domains. Findings also indicate that inter-rater reliability is mildly enhanced by a third rater but there is very little value to having more than three supervisors participate in the rating process.

Regarding the first goal, as stated above, we have 15 specific objectives conforming to the competency benchmarks. The first 10 are designated as primary competencies and the program's clinical and didactic curriculum targets the developmental level of readiness for entry to practice when the intern completes this year of training. The remaining five competency domains are designated as secondary competencies. These domains receive less attention in our curriculum and end-of-year developmental targets are lower—we expect interns to be between the developmental levels of readiness for internship and readiness for entry to practice by the end of the year for secondary competencies.

The 15 specific training objectives are as follows:

1. Professionalism—The intern will: 1.) demonstrate the ability to continually monitor and independently resolve situations that challenge professional values and integrity; 2) consistently conduct self in a professional manner across all settings; 3.) independently accept personal

responsibility across settings and contexts; 4.) independently act to safeguard the welfare of others; and 5.) demonstrate a consolidation of professional identity as a psychologist exhibited by being knowledgeable about issues central to the field and demonstrating evidence of integration of science and practice.

2. Reflective Practice/Self-Assessment/Self-Care—The intern will: 1.) demonstrate reflectivity in the context of professional practice; 2.) exhibit accurate self-assessment of competence in all competency domains, and integrate such with practice; and 3.) engage in self-monitoring of issues related to self-care and engage in prompt interventions when disruptions occur.

3. Scientific Knowledge and Methods—The intern will: 1.) independently apply scientific methods to practice; 2.) exhibit knowledge of core science; and 3.) demonstrate knowledge and understanding of scientific foundations independently applied to practice.

4. Relationships—The intern will: 1.) Develop and maintain effective relationships with a wide range of clients, colleagues, organizations and communities; 2.) manage difficult communications with advanced interpersonal skills; and 3.) will exhibit an effective command of language and ideas.

5. Individual and Cultural Diversity—The intern will: 1.) independently monitor and apply knowledge of self as a cultural being in assessment, treatment, and consultation; 2.) independently monitor and apply knowledge of others as cultural beings in assessment, treatment, and consultation; 3.) independently monitor and apply knowledge of diversity in others as cultural beings in assessment, treatment, and consultation; and 5.) apply knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity.

6. Ethical Legal Standards and Policy—The intern will: 1.) exhibit routine command and application of the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession; 2.) demonstrate a commitment to integration of ethics knowledge into professional work; and 3.) independently and consistently integrate ethical and legal standards with all foundational and functional competencies.

7. Interdisciplinary Systems—The intern will: 1.) exhibit a working knowledge of multiple and differing worldviews, professional standards, and contributions across contexts and systems, plus intermediate level knowledge of common and distinctive roles of other professionals; 2.) demonstrate beginning, basic knowledge of and ability to display the skills that support effective interdisciplinary team functioning, such as communicating without jargon, dealing effectively with disagreements about diagnosis or treatment goals, supporting and utilizing the perspectives of other team members; 3.) demonstrate skills in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation; and 4.) develop and maintain collaborative relationships over time despite differences.

8. Assessment—The intern will: 1.) independently select and implement multiple methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context; 2.) independently understand the strengths and limitations of

diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning; 3.) independently select and administer a variety of assessment tools and integrate results to accurately evaluate presenting question appropriate to the practice site and broad area of practice; 4.) utilizes case formulation and diagnosis for intervention planning in the context of stages of human development and diversity; 5.) independently and accurately conceptualize the multiple dimensions of the case based on the results of assessment; 6.) communicate results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner.

9. Intervention—The intern will: 1.) apply knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences; 2.) exhibit the ability to engage in independent intervention planning, including conceptualization and intervention planning specific to case and context; 3.) exhibit clinical skills and judgment demonstrated by ability to develop rapport and relationships with a wide variety of clients; use of good judgment about unexpected issues, such as crises, use of supervision, and confrontation in effectively delivering interventions; 4.) implement interventions with fidelity to empirical models and flexibility to adapt where appropriate; and 5.) evaluate treatment progress and modify planning as indicated, even in the absence of established outcome measures.

10. Consultation—The intern will: 1.) exhibit ability to determine situations that require different role functions and shift roles accordingly; 2.) demonstrate knowledge of and ability to select contextually sensitive means of assessment/data gathering that answer consultation referral question; 3.) Apply knowledge to promote effective assessment feedback and to articulate appropriate recommendations; and 4.) apply literature to provide effective consultative services (assessment and intervention) in most routine and some complex cases.

11. Research/Evaluation (Secondary Competency)—The intern will: 1.) demonstrate a general understanding of processes needed in the generation of knowledge; and 2.) exhibit the ability to evaluate outcome measures.

12. Supervision (Secondary Competency)—The intern will: 1.) exhibit an understanding of the complexity of the supervisory role including ethical, legal, and contextual issues; 2.) demonstrate knowledge of procedures and practices of supervision by identifying goals and tasks of supervision; 3.) exhibit knowledge of the supervision literature and of how clinicians develop into skilled professionals; 4.) exhibit knowledge about the impact of diversity on all professional settings and supervision participants; 5.) demonstrates ability to participate in the supervisory process via peer supervision; and 6.) evidence a command of and application of relevant ethical, legal, and professional standards and guidelines relevant to supervision.

13. Teaching (Secondary Competency)—The intern will: 1.) exhibit knowledge of outcome assessment of teaching effectiveness; and 2.) demonstrate the ability to apply teaching methods in multiple settings.

14. Management-Administration (Secondary Competency)—The intern will: 1.) participate in the management of direct delivery of professional services and respond appropriately in the management hierarchy; 2.) will exhibit awareness of principles of policy and procedures manual

for organizations, programs or agencies, plus awareness of basic business, financial and fiscal management issues; 3.) will recognize own role in creating policy, and in participating in system change and management structure; and 4.) exhibit ability to develop and offer constructive criticism and suggestions regarding management and leadership of the organization.

15. Advocacy (Secondary Competency)—The intern will: 1.) intervene with client to promote action on factors impacting development and functioning; and 2.) promote change to enhance the functioning of individuals.

Interns receive formal feedback regarding progress in these competency domains at the end of each of four rotations, or essentially after competing each quarter of the training program. Targeted developmental levels, expressed numerically using the developmental continuum described above, differ as a function of time spent in internship training. Specifically, expected ratings become progressively higher over the course of the training year and culminate in meeting the training objects as described above (i.e., ratings for primary competencies should be 3.0, which corresponds to the developmental level of readiness for entry to practice). The following table presents the performance ratings expected at the end of each rotation, along with the lowest acceptable ratings at each rating period. Ratings made for the 4th rotation serve as the final evaluation of the intern.

Expected Average* Performance Targets Per Rotation Sequence

	Rotation Sequence			
	1 st	2 nd	3 rd	4 th
Primary Competencies	2.25 (1.75**, 2.00)	2.50 (2.00, 2.25)	2.75 (2.25, 2.50)	3.00 (2.50, 2.75)
Secondary Competencies	1.75 (1.25, 1.50)	2.00 (1.50, 1.75)	2.25 (1.75, 2.00)	2.50 (2.00, 2.25)

* Averages are based on ratings made by each intern’s rotation supervisor, transrotational supervisor, and a minimum of one other supervisor, all of whom compose the intern’s competency committee. The rating process is explained further below.

** The first number in parentheses specifies the lowest acceptable average rating for an individual competency domain and the second number specifies the lowest acceptable average rating across all the primary or secondary domains, respectively.

NMCP Psychology Competency Assessment Toolkit: A multifaceted approach to competency assessment is incorporated in this program. As noted above, assessments are completed at the end of each of four clinical rotations, and the assessment conducted after the fourth and final rotation represents the intern’s summative competency determination for the training year. Ratings are made by the intern’s direct clinical supervisors (i.e., rotation supervisor/supervisors and the transrotational supervisor), who form the Competency Committee for each trainee. Competency Committees will be comprised of two to three supervisors, and in no instance will a

trainee be judged to be functioning below the minimally acceptable level for any competency domain, as defined in the above table, without the benefit of three raters.

The *Competency Assessment Rating Scale* is our primary tool for assessing intern competency. Using the numerical system described above (e.g., 3.00 represents readiness for entry to practice) and referencing the benchmarks document, supervisors use information obtained from direct observation plus findings from instruments/procedures described below to assign a developmental level to each of 15 training objectives/competency domains. All ratings are made independently. Average ratings are calculated and judged relative to the performance expectations as specified in the table above. (See Appendix A, page 26 of this manual, for a copy of the Competency Assessment Rating Scale).

Self-Study: At the beginning of the training year and then at the end of each rotation, interns complete a self-assessment addressing the 15 training objects/competency domains addressed in this training program. They are required to compare themselves against the competency benchmarks for each competency domain and then assign a competence rating (e.g., 2.00 for Readiness for Entry to Internship) for each, along with the justification for their rating.

Work Samples: During the last two weeks of each training rotation, outpatient, transrotational, and pain psychology supervisors will review a minimum of one audio/video tape of the intern performing a diagnostic interview and a minimum of one audio/video tape of a therapy session. Recorded materials will typically be reviewed in the presence of the intern and direct feedback provided at that time. Additionally, the supervisor will complete a multi-itemed rating scale assessing various aspects of the taped clinical performances (see Appendix B, page 49 of this manual for the Work Samples Rating Scale). These ratings are available to the intern for inspection at the end of the rotation. More than one tape is evaluated at the request of the intern in the event the intern feels the particular tape chosen by the supervisor was not representative of their best work. Supervisors also review the written documentation for the diagnostic interview, along with 2 other samples of written reports. Additionally, the progress note linked to the therapy session, and two additional progress notes for the same patient are evaluated. Interns will obtain appropriate informed consent from each patient prior to securing audio/video taped materials. The inpatient supervisor will observe the intern conduct a diagnostic interview on the ward in a treatment team setting and will read a diagnostic interview from the intern's ER rotation. Rather than listening to a therapy session and reading accompanying progress notes, the inpatient supervisor will observe the intern conduct an inpatient process group and will rate the group using the Psychiatry Inpatient Process Group Evaluation Tool. (See Appendix C, page 66 of this manual for this scale). The Internal Behavioral Health Consultant (IBHC) will observe the intern conduct an initial assessment and a follow-up appointment, as well as reviewing associated documentation and documentation for two additional follow-up appointments. The IBHC uses these observations, as well as observed interactions with treatment team members and supervisors to complete the Navy BHIP-MHP IBHC Core Competency Tool. (See Appendix D, page 68 of this manual for this scale).

Multiple Choice Tests of Reading Assignments: Interns are provided a list of required readings for each quarter addressing the 15 competency domains around which our program is

structured. At end of each rotation, interns will be given a multiple choice examination that addresses assigned readings. The exam will be composed of 75 items. This examination will be given in a take-home, open-book format. The examination will be retaken if an intern achieves a score of less than 80% correct answers. (see Appendix E, page 75 of this manual, for the year's list of reading assignments)

Multiple Choice Tests of Didactic Content: Following each didactic presentation, each intern will compose two multiple choice questions addressing the didactic content of the presentation. Items will be collated and a multiple choice test composed of intern-generated questions will be prepared for an end-of-rotation examination (given on the same day as the examination covering the reading assignments is distributed). Presenters who are on the staff of NMCP will provide evaluations of the quality of each intern question and interns will receive copies of these ratings (see Appendix F, page 82 of this manual, for a copy of this rating scale). Items on each test will be limited to the didactics offered during the rotation. Interns will have one hour to take the examination, which will be in an open-note format. Interns are expected to obtain 70% or more correct answers on this examination but it is not repeated if a lower score is obtained. Also, interns may elect to not answer questions from one didactic. This is in recognition that an intern may miss a presentation due to illness or personal leave. If more than one didactic during a particular quarter is missed, the intern is required to obtain the basic information covered by the presentation from peers--he/she may still only not respond to questions for one didactic.

End of Rotation Case Presentation: During the last week of the second and fourth rotation, interns will present a case to an audience composed of the other interns, their clinical supervisors, and other training committee members. In preparation for the case presentation, the intern will perform a focused literature review addressing an issue related to the case. Findings from this literature search will be used to inform the case presentation in a manner that demonstrates the intern's ability to engage in, and apply, scholarly activity. Additionally, during the case presentation the intern must address at least one ethical issue, one diversity issue, and comment on indications for consultation and advocacy. In addition, the intern must discuss the role of outcome measurement to the case, or provide evidence of knowledge regarding outcome assessment in the event that the case of interest did not receive psychological interventions (e.g., a case that emphasizes assessment rather than treatment). The last component of the case presentation will be discussion of an administrative process observed by the trainee to be in need of revision. The intern will describe the problem, indicate the consequences to leaving it go unchallenged, outline the benefits of correcting it, and specify a mechanism/plan to resolve the issue. The case presentation will be evaluated by supervisors with the Case Presentation Rating Scale (See Appendix G, page 85 of this manual for a copy of this rating scale) and by intern peers (see Appendix H, page 96, for a copy of the Peer Perception Survey).

360-Degree-like "Customer" Perception Surveys: Four brief survey instruments are administered during the last month of each rotation by primary rotation supervisors (excluding the Transrotational supervisors) and/or the training administrative assistant. Surveys are administered as structured interviews to three patients, two referral sources or two interdisciplinary team members (or one of each at the discretion of the rotation supervisor), and

two support personnel. Additionally, a self-report survey is completed by each intern peer at the end of case presentations. (See Appendices F -J, pages 82--101 of this manual, for these instruments).

Diversity Supervision and Consultation Log: The program's Diversity Liaison attends one supervision session conducted between each primary rotation supervisor and each intern during the second and fourth quarter in order to observe the intern's ability to address diversity issues during supervision. Additionally, the Diversity Liaison provides consultation to interns, as requested, over the course of the training year and maintains a log of the number of such requests made over the course of each rotation. At the end of each rotation/quarter, the Diversity Liaison submits to the training director an evaluation form addressing the quality of the intern's consultation requests and the quality of the intern's performance during the supervision session. (See Appendix M, page 110 of this manual, for a copy of the Diversity Consultation Survey).

Military Assessment of Symptoms and Outcomes (MASO): This is a locally developed and locally validated therapy outcome measure that is used in multiple clinics run by the Outpatient Mental Health Department. It is available for use by interns as an outcome assessment tool, though other validated outcome measures may also be used over the course of the training year, as deemed appropriate by supervisors and clinical indications. A copy of the MASO is provided in Appendix N, page 112.

Clinical/Peer Supervision Skills Rating Form: During the last rotation of the training year, interns engage in peer supervision sessions under the guidance of their Transrotational supervisor. Two audio/video tapes from supervision sessions will be made. A rating scale addressing the quality of supervision will be completed by both the supervised peer and the Transrotational supervisor following the completion of the second peer supervision session. Ratings using this same scale for the second supervision audio tape will also be made by the Training Director or Assistant Training Director. The second audio/video recording will be added to the intern's 4th rotation portfolio so as to be available to all Competency Committee Members. All supervision rating forms will also be made available to the intern's Competency Committee and will influence the rating of the Supervision competency domain. See Appendix O (page 114) for this form.

Navy Fitness Report: In addition to the assessment of psychological competencies, as outlined above, all Navy officers receive annual Fitness Reports, an evaluation of their performance both in their areas of specialization (i.e., the practice of clinical psychology) and, more generally, regarding their leadership abilities, team work, and capabilities as an officer. These reports are prepared by the Psychology Section Chair with input from both the intern and the Psychology Training Director.

Training Program Elements:

Overview: Upon entering the program, interns complete an orientation period and then are assigned to one of four clinical rotations. Prior to the start of the program, interns will have been asked to indicate their preference for either the child/family, health, or psychodiagnostic assessment rotations, and an effort will have been made to give them a preferred choice.

Additionally, they are assigned a supervisor from among the available training staff to serve as their Transrotational Evidence-Based Therapy supervisor. Major rotations are in the Adult Mental Health Clinic (2), Inpatient Psychiatry, and Health Psychology, Child/Family Psychology, or Assessment.. Rotations are approximately 3 months in length. Interns also participate in weekly didactic trainings plus a variety of other training activities. Specific descriptions of these training elements are offered below:

Orientation: The intern initially spends from 7-10 days completing hospital-wide mandated trainings (e.g., HIPPA training, Command Orientation, computerized medical record training) and attending didactics in ethics, diversity, and psychological practice in the Navy. During this period the intern completes the first entries into his/her self-study.

TRAINING ROTATIONS: The program is organized around three training environments divided into four primary rotations lasting approximately three months each—two rotations are spent in one of the training settings. Additionally, the intern participates in the Transrotational Evidence-Based Learning Experience over the course of the entire training year. Expectations for each rotation are detailed in a Supervision Contract, which is signed by the supervisor and the intern. Interns are evaluated on each of the 15 training objectives/competencies, described earlier in this document, at the end of each rotation. We do not have specific competencies assigned to individual rotations, as we view professional competencies as qualities that are expressed in a manner that is largely independent of situational contexts. We acknowledge that some rotations lend themselves more to the development of some competencies than do others (e.g., the assessment rotation offers the widest array of assessment-related learning experiences and the inpatient rotation exists within the richest interdisciplinary milieu), yet over the course of the training year each intern is afforded appropriate training experiences to meet end-of-year competency targets. Additionally, since all competencies are addressed in each rotation, poor performance on the part of an intern will not result in repeating the rotation. Rather, as described later in this document, the intern will be placed in a remedial status for the next rotation and will be provided with a written plan designed to remediate detected weaknesses in competency development. See page 19 of this manual for a complete description of this process. General descriptions of the rotation settings are as follows:

Outpatient Mental Health: The Outpatient Mental Health rotation is provided primarily through the Mental Health Department at Naval Medical Center Portsmouth. Interns complete two consecutive, three-month rotations. One rotation is spent entirely at the NMCP Outpatient Mental Health Clinic. In the other rotation, interns will have the opportunity to work under supervision at one of the outlying branch clinics for one day per week. These branch clinics are A wide assortment of clinical problems is addressed within these clinical arenas, including mood, anxiety, adjustment, and psychotic disorders plus relational and occupational problems. Interns will engage in assessment services incorporating diagnostic interviewing, and when indicated, psychological testing. They will also provide individual and group psychotherapy, with an emphasis on evidence-based intervention approaches. Additionally, in both settings exposure to interdisciplinary care activities will be provided. The incorporation of branch medical clinics exposes the trainee to a full range of acute and chronic outpatient clinical presentations and provides more in-depth exposure to issues particular to specific populations

(for example, aviation). See Appendix P (page 116) for a copy of the Outpatient Supervision Contract.

Inpatient Psychiatry: Training will occur on psychiatric units 5-E and 5-F of Building 2 of NMCP. Over the course of a 3-month training experience, the intern will spend six to seven weeks on each unit, subject to modification based on patient population. Unit 5-F provides intensive inpatient psychiatric treatment for dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus an Axis I or Axis II psychiatric disorder). Unit 5-E provides intensive inpatient psychiatric treatment for severe Axis I psychiatric illnesses. These units serve both active duty and adult family members. On both units the intern will attend and participate in morning rounds, interview new patients, develop/monitor treatment/discharge plans, provide individual therapy/crisis intervention, participate in group therapy, and conduct psychological testing as needed. The intern will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated services to patients. The intern will also consult with family members and with the commands of active duty service members to make decisions regarding military disposition. Ten times during the rotation the intern will be “on call” with psychiatric residents for emergency room psychiatric consultations. Five of those times will be from 1600 until 2200, and five will be from 1600 till the next morning. On call will occur on Friday or Saturday evenings. See Appendix Q, page 122, for a copy of the Inpatient Supervision Contract.

Health Psychology Rotation: The Health Psychology rotation is provided through two locations: The Outpatient Primary Care/Family Medicine Clinic and the Outpatient Mental Health Clinic. The Outpatient Primary Care/Family Medicine Clinic is located at Naval Medical Center Portsmouth (NMCP) and serves a diverse child, adolescent and adult outpatient clinical population. However, children and adolescents will rarely be assessed by the intern. One three month rotation is completed within this Medical Home Port (MHP) setting. The intern is supervised by an Internal Behavioral Health Consultant (IBHC) who is a Clinical Psychologist. The rotation provides the intern the opportunity to work in collaboration with primary care managers (PCMs). The intern will be supervised in the performance of brief behavioral assessments and interventions for the treatment of military personnel and family members who present with a broad range of medical and behavioral/mental health problems (e.g. sleep disturbances, pain, obesity, stress, mood disorders, adjustment disorders and trauma-related issues). The intern will develop skills in structured brief diagnostic interviewing, interventions and recommendations, evidenced based cognitive-behavioral psychotherapy and learn about psychotropic medications. An appointment is approximately 25-30 minutes and patients generally attend 1-4 appointments. Brief behavioral health measures will routinely be used during this rotation to assess patient symptoms and progress. Finally, the intern may be exposed to military-specific activities such as brief fitness-for-deployment assessments. See Appendix R, page 128 for a copy of the Outpatient Primary Care Clinic Supervision Contract. At the Outpatient Mental Health Clinic, the intern will work under the supervision of a Health Psychologist to provide pain psychology assessments and time-limited cognitive-behavioral group and individual therapy for chronic pain. The intern will gain exposure to instruments used to assess emotional and behavioral components of chronic pain.. The intern will have the opportunity to consult with physical therapists, psychiatrists, surgeons, and anesthesiologists. See Appendix S, page 133, for a copy of the Pain Psychology Supervision Contract.

Child/Family Rotation: This rotation takes place in the Child Mental Health Clinic. The rotation prepares the intern to provide assessment, intervention and consultation with families of active duty service members. Interns will develop skills in the areas of intake processing, psychological evaluation/assessment, individual, group and/or family therapy, and in consultation with primary medical care providers, commands and local school districts. The rotation emphasizes responding to the unique challenges military families face. Through a co-therapist training model, interns will learn Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for disruptive behavior and attachment problems in preschool-age children. The intern will also learn to provide Child-Adult Relationship Enhancement (CARE) groups to parents who are patients in Outpatient Mental Health to mitigate the effects of their mental health problems on their parenting. Additional groups provided in this clinic include anger management, anxiety, parenting skills, and DBT for adolescents. Other opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate. The intern will primarily be supervised by a child psychologist but will also have the opportunity to work with psychiatrists and licensed clinical social work staff. See Appendix T, page 138 for a copy of the Child/Family Supervision Contract.

Assessment Rotation: The Assessment Rotation takes place in the Warrior Recovery Center at NMCP, which houses programs for patients with PTSD and traumatic brain injury. Interns in the Assessment Rotation see a wide variety of patients referred for test-oriented psychological evaluations. The intern will evaluate cases referred for general psychodiagnostic testing from various inpatient and outpatient mental health care providers from throughout the medical center. More specifically, a number of patient referrals will be for neuropsychological evaluation for a variety of medical conditions to include traumatic brain injury, which will be seen over the course of the rotation. The intern, under supervision, will have an opportunity to learn certain test instruments, which are used in a neuropsychological evaluation, administer, and interpret these tests. The interns will discuss results with the supervisor and participate in feedback sessions with the patient (under supervision) and referral sources. The intern's training rotation will be four-tiered:

- Clinical interview (Neuropsychological (medical-based) Interview)
- Test introduction and administration
- Report writing
- Clinical feedback

The intern will also have the opportunity to participate in interdisciplinary committees on an ad hoc basis. Additionally, interns may participate in facilitating psychoeducation and therapy groups. These groups are usually composed of patients with mTBIs who are selected to participate in BTRIP, which is a two week intensive outpatient therapy program of Warrior Recovery Service. See Appendix U, page 143 for a copy of the Child/Family Supervision Contract.

Transrotational Evidence Based Therapy Experience: Interns are assigned a Transrotational supervisor at the beginning of the training year and are expected to carry two to three patients at all times for whom they provide evidence-based therapy. We incorporate a broad definition of evidence-based treatment and expect the intern to demonstrate a balance between technical fidelity to an evidence-based model and clinical judgment. Use of outcome measures is required for cases seen during this rotation. During the last quarter of the training year, the Transrotational supervisor provides supervision of the intern's peer supervision activities. See Appendix V, page 148, for a copy of the Transrotational Supervision Contract.

Supervision: Interns will receive a minimum of four hours of supervision each week. At least two of these hours will be individual supervision provided by a licensed psychologist who is part of our training faculty. The remaining two hours will be provided in either an individual or group format and may be provided by a licensed psychologist or a licensed practitioner in a related discipline; e.g., a psychiatrist. The only exception to these supervision hours will be for weeks that are primarily devoted to nonclinical activities; e.g., the orientation period, while attending training workshops). Interns can also expect significant amounts of unscheduled supervision between scheduled supervision appointments. **Supervisors are available immediately for all emergency situations that arise.** Supervisors submit forms each week documenting supervision hours (see Appendix W, page 152). These forms also document various aspects of the week's supervision, such as whether or not audio/video recordings of clinical work were reviewed, whether or not supervisors provided direct feedback to interns, and whether or not issues in the supervisor-supervisee relationship were addressed. Additionally, supervisors are required to summarize the relative emphasis of the week's supervision efforts from the perspective of the 15 Foundational and Functional competencies that form the basis of our competency determinations. This information is entered into a data base by the Training Administrative Assistant and may be accessed by interns and supervisors by request. Submission of supervision forms also provides a means of ensuring that the minimum supervision hours have been met for each training week. The Administrative Assistant scrutinizes the training hours submitted each week and if the minimum requirement has not been met she promptly informs the Training Director and the intern's rotation supervisor. The rotation supervisor then establishes a plan for making-up the missed hours and the Administrative Assistant collects documentation attesting to the success of this plan.

Reading Assignments: Interns will have assigned reading for each quarter of the training year. Readings are chosen to cover each of the 15 competency domains addressed by our training model. At the end of each quarter, which corresponds to the end of rotations, there will be a multiple choice test covering this material, as previously described. A number of the reading assignments are linked to specific didactic presentations and the intern must read these prior to the didactic. See Appendix E, page 75 of this manual, for a list of required readings assigned for each quarter of the internship year.

Didactics: Interns receive a minimum of two hours of didactic training each week, and several didactic offerings are full-day or longer training experiences. Examples of the didactic presentations scheduled for this year include the following:

Cognitive Behavioral Therapy. Six 3-hour presentations provided by Dr. Barbara Cubic, Director of the Eastern Virginia Medical School Center for Cognitive Therapy, Norfolk, VA.

Center for Deployment Psychology Workshop--All interns in military internship programs are required to attend a 5-day workshop sponsored by the Center for Deployment Psychology, which is held in Bethesda, MD. This workshop addresses multiple military- and clinically-specific aspects of deployment experiences the interns can expect to have during the time they spend in active duty military service.

Substance Misuse Treatment within a Military Treatment Setting—all interns attend a five-day orientation course provided by the Substance Abuse Rehabilitation Program located on the grounds of this medical center. Though primarily didactic in nature, this course will also afford the intern opportunities to participate in diagnostic interviews of substance abusing individuals, as well as participate in group treatment offerings.

A list of the didactic presentation topics provided each year is presented in Appendix X (page 154). Additional didactic opportunities may arise over the training year within the local psychological community and via trainings offered through the Department of Defense and Department of the Navy. As illustrated on this list, a number of the didactics have associated reading assignments.

Embedded Experiences: Interns will participate in two embedded experiences during the training year. They will spend 3-5 days aboard an aircraft carrier during which the intern will experience actual shipboard living conditions and stresses, work in the ship's Medical Department, interact with, and be educated by, successfully adapted sailors about the industrial and psychological demands of their work, and deliver psychological services under the direction of the ship's psychologist. Interns will also spend several days with psychologists at a Marine or Navy SEAL base. Particular emphasis will be placed on gaining familiarity with the operational plans and stresses unique to the Marine Corps or Special Forces, and on developing skills for effective consultation with these commands.

GRIEVANCES AND APPEAL PROCESSES

Grievance procedures for charges of harassment or other EEO issues are covered in BUMED Instruction 1524.1B, which is available on line through the internet at <http://navymedicine.med.navy.mil/default.cfm?selmod=706435D4-8C78-A781-8663C37197B239CD&seltab=Directives>. Interns wishing to make a complaint or file a grievance against the Psychology Training Program or a specific supervisor for any other reason should follow the procedure described below. The first two steps of the procedure constitute the

informal mechanisms for resolution of the dissatisfaction. The procedures thereafter are more formal ones and extend beyond the Outpatient Mental Health Department and Psychology staff.

Initially, the intern should speak to the supervisor about concerns regarding the supervisor's conduct or expectations. If these discussions do not lead to a mutually acceptable solution, the intern should bring the complaint to the Psychology Training Director. The Director will make every effort to hear both sides and determine the most appropriate resolution to the concern/complaint. In general, the Director has only a few possible options available to him/her. He/she may find in favor of the intern and instruct the supervisor in how to modify or correct the situation. He/she may find in favor of the staff member and explain to the intern why the supervisor's behavior is appropriate or acceptable within the training model. Alternatively, the Director might find that clearer understanding between the parties is necessary and can lead to a compromise that will be mutually acceptable and allow the training process to move forward. The Psychology Training Director will hold a meeting with the parties concerned and facilitate such a resolution if the parties so wish. In extreme and unusual cases the grievance may be so severe as to lead to an investigation and possible dismissal of the supervisor from the training program. If an intern has a complaint with the Training Director, the Psychology Chair (or designee) will follow the above guidelines in resolving the issue.

If these informal channels fail to bring a resolution that is satisfactory to the intern, the next step in the process would be for the intern to make a formal complaint to NMCP's Graduate Medical Education Committee (GMEC). This body, of which the Psychology Training Director is a member, will review the complaint and the documentation of attempts to deal with the problem on the local level, and will engage in an investigation of the problem. The GMEC will make a formal determination and inform all parties of the results and recommendations. In the event that the intern is still dissatisfied, a final appeal can be made to the Inspector General's Office (IG). This will lead to an independent investigation from outside the Hospital.

This constitutes the final link in the grievance chain. If the IG finds in favor of the intern, steps will be taken to remedy the situation. If the IG finds in favor of the supervisor/program, the intern will have no further recourse.

In addition to the above, at any point in the training year interns may request a review of any program policy by the Internship Training Committee. Requests to address this committee are communicated to the Training Director who then establishes this request as an item of business for the next scheduled committee meeting. Interns are informed of the time and place of this meeting. After stating their request to the committee, the intern is excused from the room while committee members debate the issue. The intern is recalled to the meeting when a decision has been reached. If the issue is not resolved to the intern's satisfaction, the above grievance policy may be applied.

DEFICIENT PERFORMANCE, TERMINATION AND DUE PROCESS

In order to receive a certificate of completion, all training elements must be satisfactorily completed. In the event that deficient performance is noted by a supervisor during a clinical rotation, the supervisor is responsible for communicating specific examples of the problem(s) and suggestions for improvement to the intern and documenting such on weekly supervision forms (see Appendix W on page 152). Performance concerns are also shared by the supervisor with members of the intern's Competency Committee and other training faculty during regularly scheduled Training Committee meetings. This is an informal process and does not result in placement of the intern into a remedial or probationary status.

If the supervisor's efforts to encourage and support improvement in performance are not successful, as indicated by the intern's failure to meet minimum competency ratings at the end of the rotation (refer to minimum requirements on page 11 of this manual), the intern is placed in remedial status while continuing on to the next rotation. The Graduate Medical Education Committee (GMEC) is informed of this action and a written plan is developed by the next rotation supervisor, in consultation with the intern's past supervisor(s), transrotational supervisor, and Competency Committee. This plan is oriented toward clearly outlining deficiencies and specifying actions the supervisors will take to support the intern in acquiring relevant skills and/or personal behaviors by the end of the next rotation. The plan is signed by the intern, supervisors and the Training Director. If the intern demonstrates adequate performance by the end of this rotation, with adequate performance defined as meeting minimum performance ratings for the rotation sequence, he/she is taken out of the remedial status and returned to good standing in the training program. The intern is provided a letter from the Training Director documenting this return to good standing. The GMEC is also informed of this outcome.

If the intern fails to meet minimum competency standards by the end of this rotation, he/she is referred to the GMEC for further action, which may include another period of departmental remediation, departmental remediation plus concurrent command probation, or termination from the training program. Recommendations by the GMEC for command probation or termination must be endorsed by leadership at the command in order to go into effect. For interns given a second period of remediation (with or without command probation), a new remediation plan is developed and signed by the intern, rotation supervisor, transrotational supervisor, and the Training Director. Additional documents through the GMEC/command leadership may be presented to the intern. If at the end of this second remediation period the intern is able to meet minimum competency levels as specified in the Training Manual, he/she is recommended by the Training Committee for return to good standing in the program. On the other hand, failure to meet minimum competency levels following this second period of remediation will typically result in a recommendation by the Competency Committee for termination, a recommendation that is handled administratively through the GMEC. Written copies of all correspondence between the Training Director, the GMEC, and the intern are maintained by the Training Director.

Given the above, it is possible that an intern may need to be extended beyond the 12-month training year due to failure to meet minimal competency requirements specified for the fourth

and final rotation. In an effort to both minimize the likelihood of this occurring and ensure that trainees are aware of this possibility, any intern placed on departmental remediation with or without command probation for the fourth rotation will receive a letter from the Training Director informing them of the possibility of an extension of the training year or eventual failure. In addition, any intern determined to be functioning above the minimally acceptable level but below the targeted level of competence at the end of the third rotation—a level of performance that maintains the trainee in good standing but which falls in a borderline range of competency development—will be deemed “at risk” for not successfully completing the program. In this case, the trainee will receive a letter from the Training Director informing him/her of the possibility of a training year extension in the event that fourth rotation competency ratings do not support successful program completion. Additionally, the intern, though not technically in a remedial status, will be given a written individualized training plan designed to maximize the likelihood of successful program completion. Training extensions will typically be for three months and will be followed by the standard end-of-rotation evaluation processes. Interns requiring an extension of training will need to meet the competency levels specified for the end of the fourth rotation in order to receive certificates of completion.

An intern may be recommended for termination from the program at any time for exhibiting flagrantly unethical behavior or illegal acts. Administrative actions in response to such behaviors are handled through the GMEC and involve the military chain of command with input from the Judge Advocate’s office. As is the case for all Navy service members, poor performance or unacceptable personal behavior will be reflected in the intern’s fitness reports which are prepared by the Psychology Chair.

The intern’s rights to due process protections are maintained throughout all actions initiated for deficient performance. Interns are entitled to representation by a Navy legal officer (attorney), free of charge.

PROGRAM EVALUATION BY INTERNS

Subsequent to beginning the training year, interns are afforded a 30-day period during which they make seek clarification or modification of this training manual. When there is 100% agreement on the part of the interns and consent by the Training Committee, modifications to the year’s training manual are made. Interns provide additional feedback regarding the adequacy of their training experiences at various points during the training year. Following each didactic presentation, they complete an evaluation form that informs the program of the adequacy of the presenter and also provides an estimate of the competency domains addressed during the presentation. (See Appendix Y, page 152) Also, at the end of each training rotation the intern completes a supervisor evaluation form which is, after review with the supervisor, submitted to the Training Director (See Appendix Z, page 159). Additionally, at the end of the training year interns complete a final evaluation of their training experiences (see Appendix AA, page 162). Finally, graduates are surveyed every year for 7 years to track their professional growth and progress toward our goal of developing psychologists who engage in lifelong learning pursuits (See Appendix BB, page 172).

POLICY ON VACATION TIME AND SICK LEAVE

The following guidelines have been developed to help staff evaluate requests by psychology interns for time away from the training program. Interns are required to plan their absences, if any, well in advance and to submit their requests in a manner that will allow adequate review by rotation supervisors, the Training Director and the Psychology Chair. It is the policy of the program to grant five working days for personal leave/vacation. Interns may also be granted, at the discretion of the Training Director and Psychology Chair, leave for defense of a dissertation. All requests for absences are contingent upon the projected requirements of the intern's training assignments and upon the intern's progress in the training program. Above all, patient care responsibilities are primary. Consideration of additional time away, such as time for attending graduation ceremonies or in the event of an unusual family emergency, will be on a case-by-case basis, and two extra days of personal leave will be granted to interns who complete dissertations and all other requirements for graduation prior to the end of the internship year. Interns should note that they will accrue 30 days of leave/vacation over the course of the year and thus will have available leave to use at their first regular duty station. Two extra days of personal leave are granted for interns who have completed all graduate school requirements (i.e., dissertations) prior to entering the internship or during the course of the training year.

Absences from the training program due to illness or injury will be monitored and recorded. In the event the intern misses more than 5 days of training due to illness, he/she will be required to complete make-up days at the end of the training year for each additional day of sick leave used. In the event of major illness or prolonged unavailability due to medical reasons (e.g., child birth followed by maternity leave), it is highly likely that the intern will need to skip a rotation and then make it up by extending the training year 3 months.

APPLICANT QUALIFICATIONS, APPLICATION PROCESS AND BENEFITS

This program is partially affiliated with the Department of Medical and Clinical Psychology of the Uniformed Services University of the Health Sciences, Bethesda, Maryland, and accepts applications from this program on a yearly basis. Other applicants are limited to persons whose graduate studies, or respecialization activities, have been financially supported by the Navy at other graduate schools (i.e., have attended graduate school on a Navy scholarship or other Navy-sponsored program). All applicants must come from APA accredited graduate programs and document a minimum of 450 hours of supervised practicum activities (i.e., direct patient contact hours) which include a balance of assessment and treatment experiences with adult clients. The program does not recruit nor accept applicants who are not currently associated with the Navy. Inquiries from such individuals are directed to the Navy's National Training Director so that they may learn of the opportunities afforded by the two Navy internship programs at the National Naval Medical Center in Bethesda, Maryland and the Naval Medical Center, San Diego, both of which participate in the APPIC match procedure. Applicants eligible for our program are not automatically accepted. We have a formal application process that must be followed in order to determine each applicant's readiness and suitability for our program. By October 1st of each year

all eligible applicants are emailed a formal application (See Appendix CC, page 187 of this manual, for a printed version of the application). Completed applications must be returned via email by November 1st, along with a letter of reference from the graduate school's training director and letters from two clinical supervisors. In the letter from the training director, it must be stated that the applicant is in good standing within the graduate program and that all pre-internship requirements will be met by the time the applicant reports for internship training. An official transcript of graduate studies must also be submitted. Materials should be submitted to the Training Director via encrypted email. Following receipt of this material, an interview with the Training Director will be scheduled, either in person or via telephone. Completed applications plus information gleaned from interviews are reviewed by the Internship Training Committee. Applicants are accepted into the program by majority vote of committee members. Given the small number of eligible applicants, processing of these documents is completed promptly and notifications of acceptance/rejection are sent to applicants no later than November 15th. This early decision date makes it possible for rejected applicants to seek internship training arrangements elsewhere.

All entering interns are commissioned officers in the Navy Medical Service Corps, with most holding the rank of Lieutenant (0-3). Those with previous Navy experience may hold a higher rank. All have completed a 5 week training program through the Officer Development School (ODS) at Newport, Rhode Island prior to entering our program. Most interns have a 3-year military service obligation following completion of the one-year training year. In some instances, the length of obligated service may differ. Continued service as a Navy psychologist beyond the internship and years of obligated service is an option. At the end of the internship year, interns will be assigned to serve in one of a variety of positions in support of the mission of the Navy and Marine Corps, including work in stateside clinics or hospitals and overseas service. Interns are expected to complete licensure requirements in the state of their choice within 18 months of completion of this program. Annual compensation here in the Portsmouth is about \$65,000. Persons with prior military service and higher rank receive more. Health care expenses are fully covered for all interns and family members, and there are other financial benefits that go along with active duty service in the Navy, such as access to military exchanges for discounts on food and other goods, life insurance, and free access to legal advice. During the training year interns are provided with appropriate office space equipped with a networked computer, are assigned a digital audio recorder, have access to two HD video cameras, and have access to support personnel for assistance with administrative tasks (e.g., opening computerized appointment schedules, booking patients). Additionally, interns have full access to a wide array of psychological testing materials and to the medical center's library facilities, which supports on-line APA journal access from the intern's office computer.

EQUAL OPPORTUNITY POLICY

The Clinical Psychology Internship Training Program operates in accordance with Naval Medical Center Portsmouth's Equal Opportunity Policy, which is as follows:

- In a positive and effective work environment, all persons are treated with respect, dignity, and basic courtesy. Discrimination on the basis of a person's race, color, nation of origin,

gender, age, or disability fundamentally violates these essential core values of respect and dignity. Discrimination demeans any work environment and degrades the good order and discipline of the military service.

- It is policy that all members of this command will conduct themselves in a manner that is free from unlawful discrimination. Equal opportunity and treatment will be provided for all personnel. We will actively seek ways to foster a positive, supportive, and harassment-free environment for all personnel, military and civilian, staff and patient. The rights of individuals to file grievances are ensured and preserved. Whenever unlawful discrimination is found, it will be eliminated and its effects neutralized. All personnel of this command hold a shared responsibility to ensure that any unlawful discrimination is eradicated and that accountability is appropriately assessed.

FOR ADDITIONAL INFORMATION

All further inquiries for information regarding this training program should be directed to:

CDR Michael Franks, Psy.D.

Training Director

Mental Health Department, Psychology Training Programs (Code 128Y00A)

Naval Medical Center

620 John Paul Jones Circle

Portsmouth, VA 23708-2197

(757) 953-7641

Michael.Franks@med.navy.mil

Questions regarding other Navy training programs and scholarships should be directed to:

Eric Getka, Ph.D.

National Training Director

Department of Psychology, (Code 0208)

National Navy Medical Center

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Bethesda, MD 20889-5600

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APPENDIX A

Competency Assessment Rating Scale

Naval Medical Center Portsmouth
Psychology Internship Training Program 2015-2016
Competency Assessment Rating Scale

Intern: _____ Rotation Supervisor(s): _____

Transrotational Therapy Supervisor: _____

Competency Committee Members: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health Transrotational

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th Rotation

This form is intended to be used in conjunction with the Internship Training Program's Competency Benchmarks document to assign competency ratings for each of seven Foundational and eight Functional competency domains at the end of the rotation noted above. Ratings are provided by rotation supervisors, transrotational supervisors, and by the intern's Competency Committee, as discussed in the program manual. In the Health rotation, rotations are made by the pain psychology supervisor and the primary care supervisor and are averaged. Ratings are based on the following developmental scale anchored by the benchmarks for each competency domain:

- 1.00 Meets criteria for Readiness for Practicum
- 1.25 Mildly exceeds some criteria for Readiness for Practicum
- 1.50 Mid-way between Readiness for Practicum and Readiness for Internship
- 1.75 Approaches or meets some criteria for Readiness for Internship
- 2.00 Meets criteria for Readiness for Internship
- 2.25 Mildly exceeds some criteria for Readiness for Internship
- 2.50 Mid-way between Readiness for Internship and Readiness for Entry to Practice
- 2.75 Approaches or meets some criteria for Readiness for Entry to Practice
- 3.00 Meets criteria for Readiness for Entry to Practice
- 3.25 Mildly exceeds some criteria for Readiness for Entry to Practice
- 3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice
- 3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice
- 4.00 Meets criteria for Readiness for Fully Autonomous Practice
- 4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice
- 4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning

- 4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning
- 5.00 Meets criteria for Entry to Life-long Learning/Master Clinician

Performance benchmarks listed on this form are for the 3.00 competency level; i.e., “Meets Criteria for Entry to Practice”. Ratings below or above this level reflect comparison of these benchmarks with those of other developmental levels as listed in the training program’s benchmark document. It is important to note that ratings are based on the judgment of the supervisor and members of the competency committee relative to stated benchmarks as informed by various sources of data (i.e., our assessment toolkit). A more complete discussion of this rating scale, along with the department’s justification for using it, is provided in the Internship Training Manual.

The training program addresses all 15 competencies but divides these into primary and secondary designations. Secondary competencies, which include Research/Evaluation, Supervision, Teaching, Management-Administration, and Advocacy, receive less attention than others and, accordingly, lower levels of competency development are required by the program for secondary competencies.

Targeted developmental levels for the rotation to which this assessment pertains differ as a function of the rotation sequence. More specifically, expected targeted ratings become progressively higher over the course of the training year. Thus an intern working, for example, in the Outpatient rotation during the first part of the year will have lower rating targets than another intern assigned to this rotation at the end of the year.

Averaged* Performance Targets Per Rotation Sequence

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th Rotation

Performance Expectations:

Primary Competencies	2.25 (1.75**, 2.00)	2.50 (2.00, 2.25)	2.75 (2.25, 2.50)	3.00 (2.50, 2.75)
Secondary Competencies	1.75 (1.25, 1.50)	2.00 (1.50, 1.75)	2.25 (1.75, 2.00)	2.50 (2.00, 2.25)

* Averages are based on ratings made by each intern’s rotation supervisor, transrotational supervisor, and a minimum of one other supervisor, all of whom compose the intern’s competency committee.

** The first number in parentheses specifies the lowest acceptable average for an individual competency domain and the second number specifies the lowest acceptable average across all the primary or secondary domains, respectively.

Foundational Competencies

1. Professionalism

Essential Component A: Continually monitors and independently resolves situations that challenge professional values and integrity

Performance Benchmarks: Articulates professional values and takes independent action to correct situations that are in conflict with professional values

Essential Component B: Consistently conducts self in a professional manner across all settings

Performance Benchmarks: Verbal and nonverbal communications are appropriate to the professional context including in challenging interactions

Essential Component C: Independently accepts personal responsibility across settings and contexts

Performance Benchmarks: Works to fulfill patient-provider contracts; Enhances productivity; Holds self accountable for and submits to external review of quality service provision

Essential Component D: Independently acts to safeguard the welfare of others

Performance Benchmarks: Communications and actions convey sensitivity to individual experience and needs while retaining professional demeanor and deportment; Respectful of the beliefs and values of colleagues even when inconsistent with personal beliefs and values; Acts to benefit the welfare of others, especially those in need

Essential Component E: Consolidation of professional identity as a psychologist; knowledgeable about issues central to the field; evidence of integration of science and practice

Performance Benchmarks: Keeps up with advances in profession; Contributes to the development and enhancement of the profession and colleagues; Demonstrates integration of science in professional practice

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Test on Assigned Readings on Professionalism; End of Rotation Didactics Test; Support Staff Survey—item 2; Patient Perception Survey—items 1,2,3,&7; Interdisciplinary Team Member Survey—items 1,2,& 3; Consultation Services Survey—items 1 & 2.

_____ **Rotation Supervisor's Rating for Professionalism**

_____ **Transrotational Supervisor's Rating for Professionalism**

_____ **Competency Committee Member's Ratings for Professionalism**

2. Reflective Practice/Self-Assessment/Self-Care

Essential Component A: Reflectivity in context of professional practice (reflection-in-action), reflection acted upon; self used as a therapeutic tool

Performance Benchmarks: Demonstrates frequent congruence between own and others' assessment and seeks to resolve incongruities; Models self-care; Monitors and evaluates attitudes and values and beliefs towards diverse others; Systematically and effectively monitors and adjusts professional performance in action as situation requires; Consistently recognizes and addresses own problems, minimizing interference with competent professional functioning

Essential Component B: Accurate self-assessment of competence in all competency domains; integration of self-assessment in practice

Performance Benchmarks: Accurately identifies level of competence across all competency domains; Accurately assesses own strengths and weaknesses and seeks to prevent or ameliorate impact on professional functioning; Recognizes when new/improved competencies are required for effective practice

Essential Component C: Self-monitoring of issues related to self-care and prompt interventions when disruptions occur

Performance Benchmarks: Anticipates and self-identifies disruptions in functioning and intervenes at an early stage/with minimal support from supervisors; Models self-care

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; and End of Rotation Test on Assigned Readings on Reflective/Practice/Self-Assessment/Self-Care.

_____ **Rotation Supervisor's Rating for Reflective Practice/Self-Assessment/Self-Care**

_____ **Transrotational Supervisor's Rating for Reflective Practice/Self-Assessment/Self-Care**

_____ **Competency Committee Member's Ratings for Reflective Practice/Self-Assessment/Self-Care**

3. Scientific Knowledge and Methods

Essential Component A: Independently applies scientific methods to practice

Performance Benchmarks: Independently accesses and applies scientific knowledge and skills appropriately and habitually to the solution of problems; Readily presents own work for the scrutiny of others

Essential Component B: Knowledge of core science

Performance Benchmarks: Demonstrates advanced level of knowledge of and respect for scientific knowledge of the bases for behavior

Essential Component C: Knowledge and understanding of scientific foundations independently applied to practice

Performance Benchmarks: Reviews scholarly literature related to clinical work and applies knowledge to case conceptualization; Applies EBP concepts in practice; Compares and contrasts EBP approaches with other theoretical perspectives and interventions in the context of case conceptualization and treatment planning

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Test on Assigned Readings on Scientific Knowledge and Methods. Case Presentation Rating Form—items 10 and 16; Peer Perception Survey—items 2, 3 & 9.

_____ **Rotation Supervisor's Rating for Scientific Knowledge and Methods**

_____ **Transrotational Supervisor's Rating for Scientific Knowledge and Methods**

_____ **Competency Committee Member's Ratings for Scientific Knowledge and Methods**

4. Relationships

Essential Component A: Develops and maintains effective relationships with a wide range of clients, colleagues, organizations and communities

Performance Benchmarks: Effectively negotiates conflictual, difficult and complex relationships including those with individuals and groups that differ significantly from oneself; Maintains satisfactory interpersonal relationships with clients, peers, faculty, allied professionals, and the public

Essential Component B: Manages difficult communications; possesses advanced interpersonal skills

Performance Benchmarks: Seeks clarification in challenging interpersonal communications; Demonstrates understanding of diverse viewpoints in challenging interactions; Accepts, evaluates and implements feedback from others

Essential Component C: Effective command of language and ideas

Performance Benchmarks: Demonstrates descriptive, understandable command of language, both written and verbal; Communicates clearly and effectively with clients

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Test on Assigned Readings on Relationships; Work Samples Rating Form—items 23 & 27; Support Staff Survey—item 1; Patient Perception Survey—item 8; Peer Perception Survey—item 12; Interdisciplinary Team Member Survey—item 5; Consultation Services Survey—item 5; Peer Supervision Rating Form—items 1 & 8.

_____ **Rotation Supervisor's Rating for Relationships**

_____ **Transrotational Supervisor's Rating for Relationships**

_____ **Competency Committee Member's Ratings for Relationships**

5. Individual and Cultural Diversity

Essential Component A: Independently monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation

Performance Benchmarks: Independently articulates, understands, and monitors own cultural identity in relation to work with others; Regularly uses knowledge of self to monitor and improve effectiveness as a professional; Critically evaluates feedback and initiates consultation when uncertain about diversity issues

Essential Component B: Independently monitors and applies knowledge of others as cultural beings in assessment, treatment, and consultation

Performance Benchmarks: Independently articulates, understands, and monitors cultural identity in work with others; Regularly uses knowledge of others to monitor and improve effectiveness as a professional; Critically evaluates feedback and initiates consultation or supervision when uncertain about diversity issues with others

Essential Component C: Independently monitors and applies knowledge of diversity in others as cultural beings in assessment, treatment, and consultation

Performance Benchmarks: Independently articulates, understands, and monitors multiple cultural identities in interactions with others; Regularly uses knowledge of the role of culture in interactions to monitor and improve effectiveness as a professional; Critically evaluates feedback and initiates consultation or supervision when uncertain about diversity issues with others

Essential Component D: Applies knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity

Performance Benchmarks: Articulates an integrative conceptualization of diversity as it impacts clients, self and others; Habitually adapts one's professional behavior in a culturally sensitive manner, as appropriate to the needs of the client, that improves client outcomes and avoids harm; Articulates and uses alternative and culturally appropriate repertoire of skills and techniques and behaviors; Seeks consultation regarding addressing individual and cultural diversity as needed; Uses culturally relevant best practices

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Tests on Assigned Readings on Individual and Cultural Diversity; Case Presentation Rating Form—items 7 & 12; Work Samples Rating Form—item 25; Patient Perception Survey—item 4; Peer Perception Survey—item 5; Diversity Consultation Survey—items 1-6; Peer Supervision Rating Scale—items 5 & 10.

_____ **Rotation Supervisor's Rating for Individual and Cultural Diversity**

_____ **Transrotational Supervisor's Rating for Individual and Cultural Diversity**

_____ **Competency Committee Member's Ratings for Individual and Cultural Diversity**

6. Ethical Legal Standards and Policy

Essential Component A: Routine command and application of the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession

Performance Benchmarks: Spontaneously and reliably identifies complex ethical and legal issues, analyzes them accurately and proactively addresses them; Awareness of potential conflicts in complex ethical and legal issues and seeks to prevent problems and unprofessional conduct; Aware of the obligation to confront peers and/or organizations regarding ethical problems or issues and to deal proactively with conflict when addressing professional behavior with others

Essential Component B: Commitment to integration of ethics knowledge into professional work

Performance Benchmarks: Applies applicable ethical principles and standards in professional writings and presentations; Applies applicable ethics concepts in research design and subject treatment; Applies ethics and professional concepts in teaching and training activities; Develops strategies to seek consultation regarding complex ethical and legal dilemmas

Essential Component C: Independently and consistently integrates ethical and legal standards with all foundational and functional competencies

Performance Benchmarks: Integrates an understanding of ethical-legal standards policy when performing all functional competencies; Demonstrates awareness that ethical-legal standards policies competence informs and is informed by all foundational competencies; Takes responsibility for continuing professional development

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Tests on Assigned Readings on Ethical Legal Standards and Policy; Case Presentation Rating Form—item 11; Peer Perception Survey—item 4.

_____ **Rotation Supervisor's Rating for Ethical Legal Standards and Policy**

_____ **Transrotational Supervisor's Rating for Ethical Legal Standards and Policy**

_____ **Competency Committee Member's Ratings for Ethical Legal Standards and Policy**

7. Interdisciplinary Systems

Essential Component A: Working knowledge of multiple and differing worldviews, professional standards, and contributions across contexts and systems, intermediate level knowledge of common and distinctive roles of other professionals

Performance Benchmarks: Demonstrates ability to articulate the role that others provide in service to clients; Demonstrates ability to work successfully on interdisciplinary team

Essential Component B: Beginning, basic knowledge of and ability to display the skills that support effective interdisciplinary team functioning, such as communicating without jargon, dealing effectively with disagreements about diagnosis or treatment goals, supporting and utilizing the perspectives of other team members

Performance Benchmarks: Demonstrates skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation

Essential Component C: Demonstrates skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation

Performance Benchmarks: Systematically collaborates successfully with other relevant partners

Essential Component D: Develops and maintains collaborative relationships over time despite differences

Performance Benchmarks: Communicates effectively with individuals from other professions; Appreciates and integrates perspectives from multiple professions

Assessment Methods: Direct supervisor observation and discussion during supervision; Review of intern's self-study; End of Rotation Test on Assigned Readings on Interdisciplinary Systems; Case Presentation Rating Form—item 8; Interdisciplinary Team Member Survey—items 4, 5 & 6.

_____ **Rotation Supervisor's Rating for Interdisciplinary Systems**

_____ **Transrotational Supervisor's Rating for Interdisciplinary Systems**

_____ **Competency Committee Member's Ratings for Interdisciplinary Systems**

Functional Competencies

8. Assessment

Essential Component A: Independently selects and implements multiple methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context

Performance Benchmarks: Demonstrates awareness and competent use of culturally sensitive instruments, norms; Seeks consultation as needed to guide assessment; Demonstrates limitations of assessment data clearly reflected in assessment reports

Essential Component B: Independently understands the strengths and limitations of diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning

Performance Benchmarks: Accurately and consistently selects, administers, and scores and interprets assessment tools with clinical populations; Selection of assessment tools reflects a flexible approach to answering the diagnostic questions; Comprehensive reports include discussion of strengths and limitations of assessment measures as appropriate; Interview and report leads to formulation of a diagnosis and the development of appropriate treatment plan

Essential Component C: Independently selects and administers a variety of assessment tools and integrates results to accurately evaluate presenting question appropriate to the practice site and broad area of practice

Performance Benchmarks: Independently selects assessment tools that reflect awareness of client populations served at practiced site; Interprets assessment results accurately taking into account limitations of the evaluation methods; Provides meaningful, understandable and useful feedback that is responsive to client need

Essential Component D: Utilizes case formulation and diagnosis for intervention planning in the context of stages of human development and diversity

Performance Benchmarks: Treatment plans incorporate relevant developmental features and clinical symptoms as applied to presenting problems; Demonstrates awareness of DSM and relation to ICD codes; Regularly and independently identifies problem areas and makes a diagnosis

Essential Component E: Independently and accurately conceptualizes the multiple dimensions of the case based on the results of assessment

Performance Benchmarks: Independently prepares reports based on assessment data; Administers scores and interprets test results; Formulates case conceptualizations incorporating theory and case material

Essential Component F: Communication of results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner

Performance Benchmarks: Writes an effective comprehensive report; Effectively communicates results verbally; Reports reflect data that has been collected via interview and its limitations

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; End of Rotation Tests on Assigned Readings on Assessment; Case Presentation Rating Form—items 1-5; Work Samples Rating Form—items 1-8, 11-15, 17-21; Peer Perception Survey—item 1.

_____ **Rotation Supervisor's Rating for Assessment**

_____ **Transrotational Supervisor's Rating for Assessment**

_____ **Competency Committee Member's Ratings for Assessment**

9. Intervention

Essential Component A: Applies knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences

Performance Benchmarks: Writes a case summary incorporating elements of evidence-based practice; presents rationale for intervention strategy that includes empirical support

Essential Component B: Independent intervention planning, including conceptualization and intervention planning specific to case and context

Performance Benchmarks: Accurately assesses presenting issues taking into account the larger life context, including diversity issues; conceptualizes case independently and accurately; Independently selects an intervention or range of interventions appropriate for the presenting issues(s)

Essential Component C: Clinical skills and judgment

Performance Benchmarks: Develops rapport and relationships with a wide variety of clients; Uses good judgment about unexpected issues, such as crises, use of supervision, confrontation; Effectively delivers intervention

Essential Component D: Implements interventions with fidelity to empirical models and flexibility to adopt where appropriate

Performance Benchmarks: Independently and effectively implements a typical range of intervention strategies appropriate to practice settings; Independently recognizes this and manages special circumstances; Terminates treatment successfully; Collaborates effectively with other providers or systems of care

Essential Component E: Evaluate treatment progress and modify planning as indicated, even in the absence of established outcome measures

Performance Benchmarks: Independently assesses treatment effectiveness and efficiency; Critically evaluates own performance in the treatment role; Seeks consultation when necessary

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; End of Rotation Tests on Assigned Readings on Intervention; Case Presentation Rating Form—item 9; Work Samples Rating Form—items 9, 16, 24, 26(a or b); Patient Perception Survey—item 9.

_____ **Rotation Supervisor's Rating for Intervention**

_____ **Transrotational Supervisor's Rating for Intervention**

_____ **Competency Committee Member's Ratings for Intervention**

10. Consultation

Essential Component A: Determines situations that require different role functions and shift roles accordingly

Performance Benchmarks: Recognizes situations in which consultation is appropriate; Demonstrates capability to shift functions and behavior to meet referral needs

Essential Component B: Knowledge of and ability to select contextually sensitive means of assessment/data gathering that answers consultation referral question

Performance Benchmarks: Demonstrates ability to gather information necessary to answer referral questions; Clarifies and refines referral question based on analysis/assessment of question

Essential Component C: Applies knowledge to promote effective assessment feedback and to articulate appropriate recommendations

Performance Benchmarks: Prepares clear, useful consultation reports and recommendations to all parties; Provides verbal feedback to consultee of results and offers recommendations

Essential Component D: Applies literature to provide effective consultative services (assessment and intervention) in most routine and some complex cases

Performance Benchmarks: Identifies and implements consultation interventions based on assessment findings; Identifies and implements consultation interventions that meet consultee goals

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; End of Rotation Tests on Assigned Readings on Consultation; Case Presentation Rating Form—item 9 & 13; Patient Perception Survey—items 5 & 6; Peer Perception Survey—item 6; Consultation Services Survey—items 3, 4 & 5.

_____ **Rotation Supervisor's Rating for Consultation**

_____ **Transrotational Supervisor's Rating for Consultation**

_____ **Competency Committee Member's Ratings for Consultation**

11. Research/Evaluation (Secondary Competency)

Essential Component A: Generation of knowledge

Performance Benchmarks: Engages in systematic efforts to increase the knowledge base of psychology through implementing and reviewing research; Uses methods appropriate to the research question, setting and/or community; Consults and partners with community stakeholders when conducting research in diverse communities

Essential Component B: Evaluation of outcomes

Performance Benchmarks: Evaluates the progress of own activities and uses this information to improve own effectiveness; Describes how outcomes are measured in each practice activity

Assessment Methods: Discussion during supervision sessions; Review of intern's self-study; End of Rotation Test on Assigned Readings on Research/Evaluation; Case Presentation Rating Form—items 10 & 16; Peer Perception Survey—items 2, 3 & 9.

_____ **Rotation Supervisor's Rating for Research/Evaluation**

_____ **Transrotational Supervisor's Rating for Research/Evaluation**

_____ **Competency Committee Member's Ratings for Research/Evaluation**

12. Supervision (Secondary Competency)

Essential Component A: Understands complexity of the supervisory role including ethical, legal, and contextual issues

Performance Benchmarks: Articulates a philosophy or model of supervision and reflects on how this model is applied in practice, including integrated contextual, legal, and ethical perspectives

Essential Component B: Knowledge of procedures and practices of supervision

Performance Benchmarks: Prepares supervision contract; Demonstrates knowledge of limits of competencies to supervise (assessed metacompetency); Constructs plan to deal with areas of limited competency

Essential Component C: Engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients

Performance Benchmarks: Clearly articulates how to use supervisory relationships to leverage development of supervisees and their clients

Essential Component D: Understanding of other individuals and groups and intersection dimensions of diversity in the context of supervision practice, able to engage in reflection on the role of one's self on therapy and in supervision

Performance Benchmarks: Demonstrates integrity of diversity and multiple identity aspects in conceptualizations of supervision process with all participants (client(s), supervisee, supervisor); Demonstrates adaptation of own professional behavior in a culturally sensitive manner as appropriate to the needs of the supervision context and all parties in it; Articulates and uses diversity appropriate repertoire of skills and techniques in supervisory process; Identifies impact of aspects of self in therapy and supervision

Essential Component E: Provides supervision independently to others in routine cases

Performance Benchmarks: Provides supervision to less advanced trainees, peers or other service providers in typical cases appropriate to the service setting

Essential Component F: Command of and application of relevant ethical, legal, and professional standards and guidelines

Performance Benchmarks: Spontaneously and reliably identifies complex ethical and legal issues in supervision, and analyzes and proactively addresses them; Demonstrates awareness of potential conflicts and complex ethical and legal issues in supervision

Assessment Methods: Review of intern's self-study; End of Rotation Test on Assigned Readings on Supervision; Peer Supervision Rating Form—items 2-9 completed by supervising psychologist and peer supervisee.

_____ **Rotation Supervisor's Rating for Supervision**

_____ **Transrotational Supervisor's Rating for Supervision**

_____ **Competency Committee Member's Ratings for Supervision**

13. Teaching (Secondary Competency)

Essential Component A: Knowledge of outcome assessment of teaching effectiveness

Performance Benchmarks: Demonstrates knowledge of one technique of outcome assessment; Demonstrates knowledge of methodological considerations in assessment of teaching effectiveness

Essential Component B: Evaluation of effectiveness of learning/teaching strategies addressing key skill sets

Performance Benchmarks: Demonstrates strategy to evaluate teaching effectiveness of targeted skill sets; Articulates concepts to be taught and research/empirical support; Utilizes evaluation strategy to assess learning objectives met; Integrates feedback to modify future teaching strategies

Assessment Methods: Review of intern's self-study; End of Rotation Test on Assigned Readings on Teaching; Case Presentation Rating Form—item 17; Peer Perception Survey—item 11; Presenter's ratings of intern's didactic questions.

_____ **Rotation Supervisor's Rating for Teaching**

_____ **Transrotational Supervisor's Rating for Teaching**

_____ **Competency Committee Member's Ratings for Teaching**

14. Management-Administration (Secondary Competency)

Essential Component A: Manages to direct delivery of professional services (DDS); awareness of basic principles of resource allocation and oversight

Performance Benchmarks: Independently and regularly manages and evaluates own DDS, identifying opportunities for improvement; Recognizes role of and need for clerical and other staff, role of human resources

Essential Component B: Awareness of principles of policy and procedures manual for organizations, programs or agencies, awareness of basic business, financial and fiscal management issues

Performance Benchmarks: Respond promptly to organizational demands; Participates in the development of policies; Functions within budget; Negotiates and collects fees, pays bills; Uses technological resources for information management; Identifies resources needed to develop a basic business plan

Essential Component C: Development of mission, goal-setting, implementing systems to accomplish goals and objectives; team-building and motivational skills

Performance Benchmarks: Develops mission or purpose of direct delivery of services and/or organizations, programs and agencies; Provides others with face to face and written directions; Demonstrates capacity to develop system for evaluating supervisees/staff/employees; Communicates appropriately to parties at all levels in the system

Essential Component D: Develops own plans for how best to manage and lead an organization

Performance Benchmarks: Articulate steps and actions to be effective manager or leader appropriate to the specifics for the organization

Assessment Methods: Direct supervisor observation of intern's ability to manage administrative tasks; Discussion during supervision sessions; Review of intern's self-study; End of Rotation Test on Assigned Readings on Management-Administration; Case Presentation Rating Form—item 7 & 15; Support Staff Survey—items 3 & 4.

_____ **Rotation Supervisor's Rating for Management-Administration**

_____ **Transrotational Supervisor's Rating for Management-Administration**

_____ **Competency Committee Member's Ratings for Management-Administration**

15. Advocacy (Secondary Competency)

Essential Component A: Intervenes with client to promote action on factors impacting development and functioning

Performance Benchmarks: Promotes client self-advocacy; Assesses implementation and outcome of client's self-advocacy plans

Essential Component B: Promotes change at the level of institutions, community, or society

Performance Benchmarks: Develops alliance with relevant individuals and groups; Engages with groups with differing viewpoints around the issue to promote change

Assessment Methods: Direct supervisor observation and discussion during supervision; Review of intern's self-study; End of Rotation Test on Assigned Readings on Advocacy; Case Presentation Rating Form—item 14; Peer Perception Survey—item 7.

_____ **Rotation Supervisor's Rating for Advocacy**

_____ **Transrotational Supervisor's Rating for Advocacy**

_____ **Competency Committee Member's Ratings for Advocacy**

Summary of Ratings:

<u>Foundational Competencies</u>	<u>Supervisor Rating</u>	<u>Transrotational Supervisor Rating</u>	<u>3rd Rating</u>	<u>Average Rating</u>
Professionalism	_____	_____	_____	_____
Reflective Practice/ Self-Assessment/Self-Care	_____	_____	_____	_____
Scientific Knowledge and Methods	_____	_____	_____	_____
Relationships	_____	_____	_____	_____
Individual and Cultural Diversity	_____	_____	_____	_____
Ethical Legal Standards and Policy	_____	_____	_____	_____
Interdisciplinary Systems	_____	_____	_____	_____
<u>Functional Competencies</u>				
Assessment	_____	_____	_____	_____
Intervention	_____	_____	_____	_____
Consultation	_____	_____	_____	_____
Research/Evaluation*	_____	_____	_____	_____
Supervision*	_____	_____	_____	_____
Teaching*	_____	_____	_____	_____
Management- Administration*	_____	_____	_____	_____
Advocacy*	_____	_____	_____	_____

* Denotes secondary competencies.

Average Rating of all Primary Competencies: _____

Average Rating of all Secondary Competencies: _____

For Rotations 1-3:

The above ratings indicate that _____ is/is not making satisfactory progress in this training program.

For Rotation 4:

The above ratings indicate that _____ has/has not successfully completed all training requirements of this training program.

Evaluation Comments: _____

Psychology Intern

Rotation Supervisor(s)

Date

Transrotational Therapy Supervisor

Competency Committee Member

APPENDIX B

Work Samples Rating Scale

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Work Samples Rating Form

Intern: _____ **Rater:** _____ **Date:** _____

For each rating requested below use the following numerical scale. The referent for the “Good” classification is the average intern at the end of the training year; i.e., the typical psychological practitioner who is ready to enter practice. Raters are encouraged to write comments in the margins and/or at the end of this form.

- 5 Outstanding
- 4 Good
- 3 Satisfactory
- 2 Needs Improvement
- 1 Deficient

Diagnostic Interview/Testing Reports

Informed consent documented Case I
Yes No

Voluntary nature of interview documented Yes No

Demographic information documented Yes No

1.) History of Presenting Issues (HPI):

- _____ 5 HPI section provides an unusually thorough description of patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, and the impact of these symptoms on patient’s social and occupational functioning. Diagnostic criteria are presented in great detail to fully support the differential diagnostic process. The HPI is clearly written, concise, and well organized. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 HPI section describes patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, and the impact of these symptoms on patient’s social and occupational functioning. Diagnostic criteria are presented to support the diagnosis. HPI section is clear, concise, and organized. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 HPI section describes patient’s symptoms, including precipitant, onset, frequency, and duration of symptoms, to support the diagnosis, but is in need of better organization and a more logical flow of information. Some information required for differential diagnosis may be inferred but not specifically stated. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 HPI section attempts to describe patient’s symptoms and functioning, but may leave out some aspects of either or both. Rationale for diagnosis is not clearly spelled out and some information

required for differential diagnosis is neither inferred nor provided. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 HPI section documents why patient is being seen, but does not include sufficient information about current symptoms or functioning to support a clear diagnostic picture. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

2.) Substance Use:

_____ 5 Reflects thorough assessment of current and history of substance use; i.e., assessment that reflects knowledge of diagnostic criteria for substance use disorders. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report reflects a thorough and accurate understanding of scores/cutoffs. Clear documentation supporting or refuting a substance use disorder is provided. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Reflects assessment of current and history of substance use in sufficient detail to rule-in or rule-out a substance use disorder. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report reflects an accurate understanding of scores/cutoffs. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Provides basic documentation of current and history of substance use or may reference and correctly interpret findings from a standard screening tool (e.g., AUDIT or CAGE). If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Reflects minimal documentation of current substance use and has no substance use history. If standard screening tools are referenced (e.g., AUDIT or CAGE), the report provides findings but does not interpret them (e. g., reports an AUDIT score of 9). If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Current substance use is either not documented or is done so very superficially. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

_____ N/A (Young child patient).

3.) Psychiatric (self and family)/Medical History:

- _____ 5 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated uncommonly well with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Patient's psychiatric, medical, and family psychiatric history is documented but not in great detail. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Patient's psychiatric, medical, and family psychiatric history is documented with some information omitted or presented in an unclear manner. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Patient's psychiatric, medical, and family psychiatric history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

4.) Psychosocial History:

- _____ 5 Patient's psychosocial history is clearly and thoroughly documented. The information is integrated uncommonly well into the biopsychosocial formulation of the case. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Patient's psychosocial history is clearly and thoroughly documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Patient's psychosocial history is adequately documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Patient's psychosocial history is documented with some information omitted. Some information may need to be clarified. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Psychosocial history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

5.) Mental Status Exam:

- _____ 5 Intern's documentation reflects unusually thorough knowledge of mental status examination. The mental status section is clearly written and is fully congruent with the overall diagnostic

impression. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

- _____ 4 Intern demonstrates good skills recording features of the mental status examination. Mental status section is clearly written. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Intern demonstrates adequate skills recording features of the mental status examination. Documentation is not specific enough in some areas. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Intern requires training to adequately document a mental status exam. Report may omit key components of the patient's mental status. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Mental Status is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

6.) Assessment of Risk to Harm Self or Others:

- _____ 5 Report reflects thorough assessment of risk to harm self or others, and is written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. A fully adequate crisis plan is documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Report reflects adequate assessment of risk to harm self or others, and reflects good knowledge of research literature on risk and protective factors for suicide and homicide. A crisis plan is documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Report reflects meaningful assessment of risk to harm self or others, and reflects basic knowledge of research literature on risk and protective factors for suicide and homicide. Crisis plans is documented but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Report reflects superficial assessment of risk to harm self or others. Risk and protective factors are not addressed and crisis plan may be absent. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Risk assessment is absent in the report or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

7.) Psychological Testing: (if applicable)

- _____ 5 Report reflects a skillful selection of psychological tests, a sophisticated interpretation of test findings, and an integration of test findings with other sources of data. Strong knowledge of psychometric methods is evident. Strong knowledge of diversity factors and ethical considerations, as they relate to psychological testing, is evident in the report.

- _____ 4 Report demonstrates good knowledge of test selection and provides accurate interpretation. Test findings are integrated with other clinical information to reach appropriate conclusions. Report reflects good working knowledge of psychometric theory and diversity/ethical factors as they relate to the testing of this patient.
- _____ 3 Report demonstrates adequate knowledge of test selection and provides a basic but accurate interpretation. Conclusions reflect some integration of test findings with other clinical information. Report reflects some knowledge of psychometric theory and diversity/ethical factors as they relate to the testing of this patient.
- _____ 2 Intern demonstrates a limited knowledge of test selection and provides a marginally accurate interpretation. Conclusions only superficially integrate test findings with other clinical information. There is little to no awareness of diversity and/or ethical issues pertinent to testing reflected in the report.
- _____ 1 Report reflects a poor understanding of psychological testing. Intern does not appear to understand the basics of test selection and interpretation, and the report does not reflect an understanding of psychometric theory nor does it address diversity/ethical considerations pertinent to the testing of this patient
- _____ N/A

8.) Diagnosis:

- _____ 5 Intern’s report reflects an unusually strong knowledge of mental health classification and provides DSM-V diagnoses that are fully supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is clearly evident in the report.
- _____ 4 Intern’s report reflects a strong knowledge of mental health classification and provides DSM-V diagnoses that are supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is either explicit or strongly inferred from the manner in which the report is written.
- _____ 3 Report reflects an understanding of diagnostic nomenclature and the DSM-V multi-axial system. Information needed to rule-in and rule-out diagnoses is adequate.
- _____ 2 Report reflects a theoretical knowledge and understanding of basic diagnostic nomenclature, but does not provide sufficient information to fully rule-in or rule-out specific diagnoses.
- _____ 1 Report reflects significant deficits in understanding of the mental health classification system and/or ability to use DSM-V criteria to develop a diagnostic conceptualization.

9.) Recommendations and Disposition

- _____ 5 Recommendations are formulated and take into account patient’s needs, military demands (if applicable), and available resources outside of the NMCP Mental Health Clinic, if applicable. The recommendations reflect solid knowledge of evidence based practice and specifies the nature of services needed in order to address the patient’s issues (e.g., return to the clinic for

psychotherapy, referral for medication management, recommendation for specialized treatment). Statements regarding prognosis are offered and for active duty service members fitness/suitability for duty is clearly documented and explained.

- _____ 4 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the NMCP Mental Health Clinic, if applicable. A general description of the types of services needed to address the patient's concerns is offered and is reasonably complete, though not highly specific. Fitness/suitability for duty is clearly documented for active duty members but may not be fully explained.
- _____ 3 Intern formulates recommendations that include appropriate general plans for treatment or referral but recommendations may lack specificity or may fail to take into account available community/military resources. Fitness/suitability for duty is documented but not explained.
- _____ 2 Intern is unable to specify more than a very general and nonspecific post-interview plan for the patient. It may not be clear whether or not the patient is returning to the clinic for additional services, if referrals have been made for treatment elsewhere, and/or if follow-up treatment is needed. Statement regarding fitness/suitability for duty may be absent or inaccurate.
- _____ 1 Intern does not provide recommendations for post-interview follow-up care, or provides recommendations that are clearly inappropriate.

10.) Sensitivity to Diversity Issues:

- _____ 5 Report reflects strong awareness of cultural issues relevant to the particular patient, including how these issues may influence the patient's psychosocial history, current symptoms, and focus of treatment (if applicable). When appropriate, attention is given to how cultural differences between the intern and the patient could have affected the patient's clinical presentation in the interview.
- _____ 4 Report reflects awareness of cultural issues relevant to the particular patient, including how these issues may influence reported the patient's psychosocial history, current symptoms, and focus of treatment (if applicable).
- _____ 3 Intern demonstrates basic knowledge of cultural issues relevant to the patient and makes an attempt to incorporate these issues into the report.
- _____ 2 The report acknowledges the patient's particular cultural background but does not comment meaningfully on it.
- _____ 1 The report omits any mention of the person's cultural background.
- _____ N/A- No relevant diversity issues in need of attention in this report are noted by rater.

11.) Overall Written Communication Skills

- _____ 5 Report is clear and thorough, follows a coherent and logical outline, and is an effective summary of major relevant issues. Recommendations are reflect and unusual degree of analysis and synthesis of the information presented.

- _____ 4 Report is clear and summarizes major relevant issues. Recommendations are useful and related to the referral question.
- _____ 3 Report covers essential points without serious error but needs polish in cohesiveness and organization. Recommendations are useful and relevant but may not fully address the referral question. Grammatical/spelling errors are absent.
- _____ 2 Report covers most essential points, but fails to summarize patient information into a cohesive report. Report reflects difficulty in formulating recommendations to appropriately answer referral questions. The report may have minor grammatical/spelling errors.
- _____ 1 Report has incomplete information, lack of structure or confusing organization, poor grammar or spelling, or inconsistent information. Report may contain material that does not apply to current patient.

Therapy Progress Notes: Ratings are based on review of 3 consecutive progress notes from the same patient. In instances of differing quality of documentation, the most recent work sample should receive the heaviest weighting.

12.) Subjective:

- _____ 5 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and reflects judicious selection of information that addresses important clinical issues without unduly divulging personally sensitive information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and free of extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is either not concise or contains some extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Documentation addresses current issues/status independently of the context of initial presentation and prior sessions. Note is either inappropriately brief or contains clearly extraneous information. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Note does not provide information regarding patient’s current concerns or does so in a manner that shows no continuity with previous sessions and/or is not clearly written. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

13.) Objective: Observed Features

- _____ 5 Intern documents objective status of the patient in a manner that reflects an uncommonly thorough understanding of the observable features of the mental status examination and in a manner that reflects session to session variability in the patient's presentation. Documentation does not give the impression that a formal mental status examination was conducted unless that was indeed the case. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Intern documents objective status of the patient in a manner that reflects a solid understanding of the observable features of the mental status examination and in a manner that reflects some session to session variability in the patient's presentation. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Notes reflect the recording of objective features of the patient's status at each session in a manner that reflects a basic understanding of the observable features of a mental status examination. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Intern's notes contain fragments of a mental status-like examination in reporting objective features of the patient's status in each session. There may be little session to session variability and there is the appearance of inappropriate cutting and pasting from past notes. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 One or more note does not reflect objective features of the patient's status at time of therapy session. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

14.) Objective: Measurements

- _____ 5 Progress notes include data from one or more objective tests/instruments designed to evaluate session by session patient status/outcomes. Outcome measures are appropriate for the presenting problem. Notes provide accurate and appropriate interpretation of these data relative to treatment goals and prior test scores.
- _____ 4 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome. Notes provide a basic interpretation of these data relative to treatment goals and prior test scores.
- _____ 3 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome but the instrument may not be well matched to the problem being treated . Notes may not provide an interpretation of the finding relative to treatment goals and/or prior test scores.
- _____ 2 At least one note contains data from an objective test/instrument designed to evaluate session by session patient status/outcome, but does not contain an interpretation of the findings or provides an incorrect interpretation of the finding.
- _____ 1 None of the progress notes contains data from an objective test/instrument.

15.) Assessment of Suicide and Homicide Risks:

- _____ 5 Notes reflect an unusually thorough session by session assessment of risk to harm self or others, and are written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. Note refers to prior findings as needed and does not imply that a comprehensive risk assessment was performed within the course of the therapy appointment unless the particulars of the case demonstrate that such was needed. When indicated by case demands, a fully adequate crisis plan is documented in each progress note in a manner that does not suggest simple cutting and pasting of information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.
- _____ 4 Notes reflect a thorough session by session assessment of risk to harm self or others, and reflect good knowledge of research literature on risk and protective factors for suicide and homicide. Note does not document information that was not actually collected during the session but may make reference to findings previously established. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.
- _____ 3 Notes reflect meaningful assessment of risk to harm self or others, and reflect basic knowledge of research literature on risk and protective factors for suicide and homicide. A basic crisis plan is documented, if indicated by the particulars of the case, but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.
- _____ 2 Notes reflects superficial or inconsistent assessment of risk to harm self or others. Risk and protective factors are not addressed in the note nor are they referenced from previous encounters. A crisis plan is indicated for the case but is missing or inadequate. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.
- _____ 1 Risk assessment is absent in one or more of the progress notes. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

16.) Treatment Plan

- _____ 5 Progress notes include a treatment plan that is consistent with patient's needs, military demands, cultural diversity issues, and ethical practice guidelines. The plan reflects solid knowledge of evidence based practice and specifies goals of treatment in measurable terms linked to specific outcome measures. Treatment modalities are clearly specified and current status, as per outcome measure assessment, is documented relative to initial presentation and relative to specified treatment goals. Modifications of the treatment plan reflect clear changes in the diagnostic formulation or are based on analysis of outcome data. Consultations with other members of the treatment team are referenced, as are efforts to advocate on behalf of the patient.
- _____ 4 Progress notes include a treatment plan that is consistent with patient's needs, military demands, cultural diversity issues, and ethical practice guidelines. The plan reflects awareness of evidence based practice and specifies goals of treatment, treatment modality and expected length of treatment. Outcome measures are incorporated directly into the treatment plan and treatment

goal-setting. Indications for changes in the treatment plan are reported, as is the basis for such. Documentation reflects awareness of the efforts of other members of the treatment team.

- _____ 3 Progress notes include a basic treatment plan that is appropriate for the patient but one that is not highly reflective of unique patient needs or military demands. There is no indication that diversity issues and/or ethical issues impacted formation of treatment plan. Treatment goals are not expressed in measurable terms and/or not directly linked to an outcome measure. Current patient status
- _____ 2 Progress notes include a basic treatment plan that is appropriate for the patient but is lacking in detail and is not reflective of unique patient needs or military demands. Opportunities to incorporate diversity issues and/or ethical considerations appear to have been missed. Treatment goals are not operationalized, treatment modalities are not adequately described, and/or current status of the patient relative to the presenting problem(s) is not described in objective terms.
- _____ 1 Notes provide no treatment plan or one that appears to be either a template (i.e., the same plan used for every patient) or inappropriate.

Evaluation of Recorded Diagnostic Interview

Intern status explained/informed consent obtained	Yes	No	
Boxer law and voluntary nature of the interview addressed	Yes	No	N/A
If involuntary, Boxer procedure followed appropriately	Yes	No	N/A

17.) Assessing Presenting Problem:

- _____ 5 Assesses the referral question in an uncommonly thorough manner. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning. Asks clarifying questions to support differential diagnosis with an unusual level of skills. Assesses all major psychiatric/psychological symptoms, including those that are not spontaneously presented by the patient.
- _____ 4 Assesses the referral question thoroughly. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning. Asks clarifying questions to support differential diagnosis.
- _____ 3 Assesses the referral question adequately. Inquires about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning.
- _____ 2 Assesses the referral question by inquiring about patient's symptoms, however, the assessment is incomplete. May leave out precipitant, onset, duration and/or frequency of symptoms, or fails to assess the impact of these symptoms.
- _____ 1 Unable to generate appropriate questions to address the referral question. Symptoms are collected in a random fashion as reported by the patient.

18) History Taking:

- _____ 5 Assesses patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history in an unusually thorough manner. Interview style is indicative of intern's ability to form questions that relate historic data to current symptoms and possible diagnoses. Asks appropriate follow up questions that fully clarify the historical picture with special reference to Axis II features and developmental disorders.
- _____ 4 Assesses patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history thoroughly. Asks appropriate follow up questions that are adequate for assessing presence or absence of Axis II features and developmental disorders .
- _____ 3 Collects adequate historic and relevant information. May fail to ask important follow up questions at times during the interview and does not obtain adequate information relevant to Axis II and/or developmental disorders .

- _____ 2 Struggles to gather relevant historical data and frequently fails to ask important follow up questions and/or leaves out important information in the interview.
- _____ 1 Clearly fails to gather significant parts of the patient’s psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and/or substance use history.

19.) Mental Status Exam:

- _____ 5 Intern conducts an uncommonly thorough mental status exam in the interview, appropriate to the referral question and patient presentation. The examination covers all components of a mental status examination as outlined by Trezepacz & Baker (1993)
- _____ 4 Intern conducts a thorough mental status exam that taps most components of a mental status examination as outlined by Trezepacz & Baker (1993)
- _____ 3 Intern performs a brief but adequate mental status exam. Some components of the full mental status examination may be missing, as per Trezepacz & Baker (1993)
- _____ 2 Intern performs a mental status exam in a poorly organized fashion and neglects important components.
- _____ 1 There is no indication that intern is performing a mental status exam.

20.) Assessment of Suicide and Homicide Risks:

- _____ 5 Intern assesses suicide and homicide risks fully and in an uncommonly thorough manner. Interview style reflects strong knowledge of research literature on risk and protective factors for suicide and homicide. If indicated, intern discusses a well thought-out crisis plan with the patient in a clear and appropriate manner.
- _____ 4 Intern assesses suicide and homicide risks thoroughly. Interview style reflects good working knowledge of risk factors literature. If indicated, intern discusses a crisis plan with the patient in a clear and appropriate manner.
- _____ 3 Intern assesses suicide and homicide risks adequately. Interview style reflects rudimentary knowledge of research on risk factors. If indicated, intern discusses a basic crisis plan with the patient.
- _____ 2 Intern assesses suicide and homicide risks superficially. May fail to ask appropriate probing questions about risk factors, fail to assess protective factors, and/or fail to discuss with the patient, if indicated, a crisis plan.
- _____ 1 Intern fails to recognize safety issues and does not ask questions about suicidal/homicidal ideations, intent or plan.

21.) Interview Skills:

- _____ 5 Interview is unusually well organized and flows naturally. Intern conveys warmth, genuineness and empathy during the interview. Intern recognizes patient’s emotions in the interview, is

sensitive to patient's emotional states and cultural background, and is able to ask questions regarding sensitive material. Intern is able to build therapeutic alliance with the patient in the interview.

- _____ 4 Interview is well organized. Intern recognizes patient's emotions in the interview, is sensitive to patient's cultural background, and is able to ask questions regarding sensitive material. Intern is able to build a therapeutic alliance with the patient in the interview.
- _____ 3 Intern demonstrates adequate information gathering skills and is aware of patient's cultural background. Interview is organized and intern is flexible in the interview to accommodate patient's emotional needs or cultural background.
- _____ 2 Intern is able to gather information through pre-selected structured questions. Intern is not flexible in the interview to accommodate patient's emotional needs or cultural background. Intern is unable to convey warmth or empathy and/or is unable to build therapeutic alliance with the patient.
- _____ 1 Intern asks questions in a seemingly random fashion, is insensitive to patient's emotions and cultural background, and/or does not foster a good working alliance with the patient.

22.) Feedback/Follow up plan:

- _____ 5 Intern provides appropriate feedback to the patient/family regarding the diagnosis if there is one, provides psychoeducation about the diagnosis if appropriate, provides an overview of the treatment to be offered, and instills a sense of hope in the patient for recovery. Makes an appropriate follow up plan with the patient and may initiate homework for the next session if appropriate.
- _____ 4 Intern provides appropriate feedback to the patient/family regarding diagnosis if there is one, and provides information about the diagnosis and available treatment. Intern makes an appropriate follow up plan with the patient.
- _____ 3 Intern ends the interview with a sufficient summary of the intake session and schedules a follow up appointment with the patient/family for further assessment or treatment, or reviews other recommendations (e.g., referral to another professional).
- _____ 2 Intern provides only limited feedback to the patient/family at the end of the interview and the follow-up plan is vague.
- _____ 1 Intern ends the interview without reviewing findings with patient/family and offers no plan for future treatment or referral.

Evaluation of Recorded Therapy Session

23.) Therapeutic Relationship:

- _____ 5 Intern demonstrates a strong therapeutic alliance with patient. Intern appears comfortable and relaxed in session, and handles anxiety-provoking or awkward situations effectively so that they do not undermine therapeutic success.
- _____ 4 Intern demonstrates a positive therapeutic alliance with patient. Intern is generally comfortable and relaxed in session, but may occasionally appear anxious in awkward situations. Intern is able to process these situations with patient.
- _____ 3 Intern demonstrates an adequate relationship with patient. Intern may occasionally appear anxious in awkward situations.
- _____ 2 Intern demonstrates marginal rapport with patient and/or appears anxious or awkward during much of the session.
- _____ 1 Intern alienates patient and/or shows little ability to recognize problems in the therapeutic relationship.

24.) Therapy Skills:

- _____ 5 Intern tracks or reflects patient statements in session with a high level of skill, and maintains patient's motivation to work. Intern balances tracking functions with guiding functions unusually well.
- _____ 4 Intern tracks or reflects patient statements in session, and maintains patient's motivation to work. Intern balances tracking functions with guiding functions.
- _____ 3 Intern tracks or reflects patient statements in session most of the time, but at times seems to follow own agenda. Intern tries to maintain patient's motivation by periodically checking-in with patient.
- _____ 2 Intern follows own agenda in the session but is able to respond to patient's needs when patient explicitly voices them.
- _____ 1 Intern pursues own agenda in the session and is insensitive to patient's needs or motivational level.

25.) Sensitivity to Diversity Issues:

- _____ 5 Intern takes the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables comfortably and sensitively with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session. If the patient is from a distinct minority group, it is apparent that the intern has an understanding of how that culture may influence mental health issues.
- _____ 4 Intern takes the initiative to discuss individual differences in terms of race, ethnicity, culture, and other individual difference variables with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session.
- _____ 3 Interns shows adequate ability to discuss differences that exist between self and patient in terms of race, ethnicity, culture and other individual difference variables. Intern does not initiate discussion with patient about these differences unless brought up by patient. Intern is open to patient discussing experiences related to cultural background but does not specifically ask about these experiences.
- _____ 2 Intern may acknowledge some individual cultural identity variables but appears uncomfortable discussing them. Intern misses clear opportunities to inquire about the impact of the patient's cultural background on current or past experiences.
- _____ 1 The intern demonstrates a fundamental lack of understanding of cultural/diversity issues, such as prescribing interventions contrary to a cultural norm or dismissing patient's concerns about individual difference variables.
- _____ N/A –No relevant diversity issues in need of attention during session are noted by rater.

26a.) Intervention (Cognitive Processing Therapy or Prolonged Exposure Therapy):

- _____ 5 Intern follows the protocol closely and skillfully. Intern appears exceptionally comfortable and familiar with the protocol and does not appear to be reading from a script. Intern adapts explanations to suit the patient's level of education and psychological-mindedness. Intern redirects the patient to stay on protocol in a way that allows patient to feel supported regarding current stressors or distress.
- _____ 4 Intern follows the protocol closely. Intern appears comfortable and familiar with the protocol and does not appear to be reading from a script. Intern adapts explanations to suit the patient's level of education and psychological-mindedness.
- _____ 3 Intern follows the protocol closely with only minor deviations. Intern appears comfortable with the protocol. Intern checks with patient to ensure understanding and provides further explanation if needed.
- _____ 2 Intern has difficulty staying on track with the protocol. Intern may have difficulty allotting time to session components and fails to finish the session. Or intern may follow the timeline rigidly even when the patient clearly does not understand or accept the intervention.

_____ 1 The session does not appear to follow either CPT or PE protocol.

26b.) Intervention (CBT,ACT, DBT, Child Therapy, Crisis Management):

_____ 5 Interventions are well-timed, effective and consistent with empirically supported treatment protocol. Reflect strong knowledge of current literature on evidence based treatments. Intern tracks or reflects patient statements in session with a high level of skill, and maintains patient's motivation to work. Intern balances tracking functions with guiding functions unusually well.

_____ 4 Most interventions and interpretations facilitate patient acceptance and change. Reflect good knowledge of current literature on evidence based treatments. Intern tracks or reflects patient statements in session, and maintains patient's motivation to work. Intern balances tracking functions with guiding functions.

_____ 3 Many interventions and interpretations are delivered and timed well. Some interventions need to be clarified and adjusted to patient's needs. Demonstrates basic knowledge of current literature on evidence based treatments. Intern tracks or reflects patient statements in session most of the time, but at times seems to follow own agenda. Intern tries to maintain patient's motivation by periodically checking-in with patient.

_____ 2 Some interventions are accepted by the patient while many others are rejected by patient. Intern sometimes has difficulty targeting the interventions to patient's level of understanding and motivation. Intern may follow own agenda in the session but responds to patient's needs when patient explicitly voices them. Alternatively, intern's agenda may be unclear, and the session may lack structure.

_____ 1 Most interventions and interpretations are rejected by patient. Intern has frequent difficulty targeting interventions to patient's level of understanding and motivation. Demonstrates no knowledge of evidence based treatments. Or intern provides an intervention that is clearly inappropriate.

27.) Interpersonal Process

_____ 5 Intern's style reflects a strong ability to use personal responses to the patient to formulate hypotheses about the patient during the session. Intern responds appropriately to metaphoric and nonverbal content, and recognizes and highlights underlying affect, cognition or themes from content. Intern appears to be aware of own issues that impact therapeutic process, and discusses/processes transference/countertransference issues effectively in the session when indicated.

_____ 4 Intern's style reflects an ability to use personal response to the patient to formulate hypotheses about the patient during the session. Intern responds appropriately to metaphoric and nonverbal content, and recognizes underlying affect, cognition or themes from content.

_____ 3 Intern appears to identify own emotional reactions to patient as countertransference. Most of the time, intern responds appropriately to metaphoric and nonverbal content, and recognizes underlying affect, cognition or themes from content.

- _____ 2 Intern has difficulty responding appropriately to metaphoric and nonverbal content due to not recognizing underlying affect, cognition or themes from content. Intern appears to have difficulty understanding own emotional response to patient and does not address the issue of transference/countertransference.

- _____ 1 Intern is unable or unwilling to recognize or work with countertransference issues and/or the intern does not address the interpersonal process in therapy and works only with explicit verbal content.

- _____ N/A –No relevant interpersonal process issues in need of attention during session are noted by rater.

Comments: _____

Appendix C
Psychiatry Inpatient Process Group Evaluation Tool

Psychiatry Inpatient Process Group Evaluation Tool

Element	Behavioral Anchor	Skill Rating (1=low; 5=high)					Comments
		1	2	3	4	5	
1. Opening Remarks	Welcomes group members, clearly states purpose of group, and establishes calm therapeutic setting.						
	Clearly describes group rules and limits of confidentiality.						
2. Group Processes	Facilitates discussion in calm, empathic, and non- obtrusive manner.						
	Calmly accepts points of silence and provides comments at therapeutically appropriate moments.						
	Effectively utilizes statements of clarification, validation, and challenge to encourage total group participation						
	Effectively manages difficult patients, such as members who monopolize discussion, display aggressive responses, or who may not be participating.						
3. Closing	Provides closing summary that fosters encouragement, validation, and underscores possible strategies/new behaviors that group members could utilize in between sessions.						
	Effectively assesses for safety prior to dismissal.						
	After group, checks on any participant about whom there may be concern.						
4. Debriefing with supervisor	Demonstrates awareness of each member's level of participation and mood state.						
	Demonstrates awareness of any counter-transference.						
	Awareness and honesty about points/moments of personal challenge or struggle.						

Appendix D
Navy BHIP-MHP IBHC Core Competency Tool

Navy BHIP-MHP IBHC Core Competency Tool

Name:

Date:

Rater:

Training Phase: II or III or Other

Use a rating scale of 1 = low skills to 5 =high skills to assess current level of skill development for all attributes within each dimension. Check in the column corresponding to the rating that best describes the trainee’s current skill level. *Competency Tool:* IBHC mentor rates the IBHC trainee based on their observations for each dimension (verbal feedback is also strongly recommended). A rating of 3 or higher is considered satisfactory for training. *For Phase II Training, only unshaded items will be rated. For Phase III Training, all items (shaded and unshaded) will be rated.*

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
I. Clinical Practice Knowledge and Skills	1. Role definition	Says introductory script smoothly, conveys the IBHC role to all new patients, and answers patient’s questions						
	2. Problem identification	Identifies and defines the presenting problem with the patient within the first half of the initial 30-minute appointment						
	3. Assessment	Focuses on current problem, functional impact, and environmental factors contributing to/maintaining the problem; uses tools appropriate for primary care						
	4. Problem focus	Explores whether additional problems exist, without excessive probing						
	5. Population-based care	5.a. Understands the difference between population-based and case-focused approach						
		5.b. Provides care along a continuum from primary prevention to tertiary care; develops/uses pathways to routinely involve IBHC in care of chronic conditions						
	6. Biopsychosocial approach	Understands relationship of medical and psychological aspects of health						
7. Use of evidence-based interventions	Utilizes evidence-based recommendations/interventions suitable for primary care for patients and PCMs							

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
I. Clinical Practice Knowledge and Skills (cont'd)	8. Intervention design	8.a. Bases interventions on measurable, functional outcomes and symptom reduction						
		8.b. Uses self-management, home-based practice						
		8.c. Uses simple, concrete, practical strategies, based on empirically supported treatments for primary care						
	9. Multi-patient intervention skills	Works with PCMs to provide classes and/or groups in format appropriate for primary care (e.g., drop-in stress management class, group medical visit for a chronic condition)						
	10. Pharmacotherapy	Can name basic psychotropic medications; can discuss common side-effects and common myths; abides by recommendation limits for non-prescribers. Consults with External Behavioral Health Consultant (EBHC) when needed						
II. Practice Management Skills	1. Visit efficiency	30-minute visits demonstrate adequate introduction, rapid problem identification and assessment, and development of intervention recommendations and a plan						
	2. Time management	Stays on time when conducting consecutive appointments						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
II. Practice Management Skills (cont'd)	3. Follow-up planning	Plans follow-up for two weeks or one month, instead of every week (as appropriate); alternates follow-ups with PCMs for high-utilizer patients						
	4. Intervention efficiency	Completes treatment episode in four or fewer visits for 85% or more of patients; structures behavioral change plans consistent with time-limited treatment						
	5. Visit flexibility	Appropriately uses flexible strategies for visits: 15 minutes, 30 minutes, phone contacts, secure messaging						
	6. Triage	Attempts to manage most problems in primary care, but does triage to mental health, chemical dependency, or other clinics or services when necessary						
	7. Case management	7.a. Utilizes patient registries (if they exist); takes load off of PCM (e.g., returns patient calls about behavioral issues); advocates for patients.						
		7.b. Refers and coordinates with PCMH Behavioral Health Case Manager (BHCM) and External Behavioral Health Consultant (EBHC)						
	8. Community resource referrals	Is knowledgeable about and makes use of community resources (e.g., refers to community self-help groups, etc).						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
III. Consultation Skills	1. Referral clarity	Is clear on the referral questions; focuses on and responds directly to referral questions in PCM feedback						
	2. Curbside consultations	Successfully consults with PCMs on-demand about a general issue or specific patient; uses clear, direct language in a concise manner						
	3. Assertive follow-up	Ensures PCMs receive verbal and/or written feedback on patients referred; interrupts PCM, if indicated, for urgent patient needs						
	4. PCM education	Delivers brief presentations in primary-care staff meetings (PCM audience; focus on what you can do for them, what they can refer, what to expect, how to use IBHC optimally, etc.)						
	5. Recommendation usefulness	Recommendations are tailored to the pace of primary care (e.g., interventions suggested for PCMs can be done in one to three minutes)						
	6. Value-added orientation	Recommendations are intended to reduce physician visits and workload (e.g., follow-up with IBHC instead of PCM)						
	7. Clinical pathways	Participates in team efforts to develop, implement, evaluate, and revise pathway programs needed in the clinic						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
IV. Documentation Skills	1. Concise, clear charting	Clear, concise notes detail: <ul style="list-style-type: none"> • Referral problem specifics • Functional analysis • Pertinent history • Impression • Specific recommendations and follow-up plan 						
	2. Prompt PCM feedback	Written and/or verbal feedback provided to PCM on the day the patient was seen						
	3. Appropriate format	Chart notes use SOAP format						
V. Administrative Knowledge and Skills	1. IBHC policies and procedures	Understands scheduling, templates, MEPRS codes for PCMH work, criticality of accurate ADS coding						
	2. Risk-management protocols	Understands limits of existing IBHC practices; can describe and discuss how and why informed consent procedures differ, etc.						
	3. KG ADS (coding) documentation	Routinely and accurately completes coding documentation						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
VI. Team Performance Skills	1. Fit with primary care culture	Understands and operates comfortably in fast-paced, action-oriented, team-based culture						
	2. Knows team members	Knows the roles of the various primary care team members; both assists and utilizes them						
	3. Responsiveness	Readily provides unscheduled services when needed (e.g., sees patient during lunch time or at the end of the day, if needed)						
	4. Availability	Provides on-demand consultations by beeper or cell phone when not in the clinic; keeps staff aware of whereabouts						

Phase II Training

Successful completion requires *all unshaded items* rated at “3” or higher

Date of successful completion: _____

Trainer signature: _____

Phase III Training

Successful completion requires *all items (shaded and unshaded)* rated at “3” or higher

Date of successful completion: _____

Trainer signature: _____

APPENDIX E

Assigned Readings

General Reading List per Competency Domains

Competency Domains	First Rotation	Second Rotation	Third Rotation	Fourth Rotation
Professionalism	<p>Fouad, N., Hatcher, R., Hutchings, P., Collins, F., Grus, C., Kaslow, N., Madson, M., & Crossman, R. (2009). Competency Benchmarks: A model for understanding and measuring competence in professional psychology across training levels. <i>Training and Education in Professional Psychology</i>, 3(4), S5-S26.</p> <p>Kaslow, N., Campbell, L., Hatcher, R., Grus, C., Fouad, N., & Rodolfa, E. (2009). Competency assessment toolkit for professional psychology. <i>Training and Education in Professional Psychology</i>, 3(4), S27-S45.</p>	<p>Donovan, R., & Ponce, A. (2009). Identification and measurement of core competencies in professional psychology: Areas for consideration. <i>Training and Education in Professional Psychology</i>, 3(4), S46-S49.</p> <p>McCutcheon, S. (2009). Competency benchmarks: implications for internship training. <i>Training and Education in Professional Psychology</i>, 3(4), S50-S53.</p>	<p>Schulte, A., & Daly, E. (2009). Operationalizing and evaluating professional competencies in psychology: Out with the old, in with the new? <i>Training and Education in Professional Psychology</i>, 3(4), S54-S58.</p> <p>Kenkel, M. (2009). Adopting a competency model for professional psychology: Essential elements and resources. <i>Training and Education in Professional Psychology</i>, 3(4), S59-S62.</p>	<p>Belar, C. (2009). Advancing the culture of competence. <i>Training and Education in Professional Psychology</i>, 3(4), S63-S65.</p> <p>DeMers, S. (2009). Real progress with significant challenges ahead: Advancing competency assessment in psychology. <i>Training and Education in Professional Psychology</i>, 3(4), S66-S69.</p>
Reflective practice/Self-Assessment/Self-Care	<p>Covey, S. (1989). <i>The 7 Habits of Highly Effective People</i>. New York. Fireside. Part One and Part Two.</p>	<p>Covey, S. (1989). <i>The 7 Habits of Highly Effective People</i>. New York. Fireside. Part Three.</p>	<p>Covey, S. (1989). <i>The 7 Habits of Highly Effective People</i>. New York. Fireside. Part Four.</p>	<p>APA Board of Professional Affairs' Advisory Committee on Colleague Assistance. (2010). Professional health and well-being for psychologists. Retrieved from http://www.apaprac</p>

				ticecentral.org/ce/self-care/well-being.aspx
Scientific Knowledge and Methods	Kazdin, A. (2003). <i>Methodology: What is it and why is it so important.</i> In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research.</i> (pp. 5-22). Washington, DC: American Psychological Association.	Sternberg, R. & Grigorenko, E. (2003). <i>Unified Psychology.</i> In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research.</i> (pp. 23-47). Washington, DC: American Psychological Association.	Nathan, P., Stuart, S., & Dolan, S. (2003). <i>Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis?</i> In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research.</i> (pp. 505-546). Washington, DC: American Psychological Association.	Wilson, D., & Lipsy, M. (2003). <i>The role of method in treatment effectiveness research: Evidence from meta-analysis.</i> In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research.</i> (pp. 589-615). Washington, DC: American Psychological Association.
Relationships	Mangione, L. & Nadkarni, L. (2010). <i>The relationship competency: Broadening and deepening.</i> In M. Kenkel & R. Peterson (Eds.), <i>Competency-based education for professional psychology.</i> (pp. 69-86). Washington, DC: American Psychological Association.	Falender, C., & Shafranske, E. (2004). <i>Clinical supervision: A competency-based approach.</i> Washington, DC: American Psychological Association. Chapter 5	Safran, J. & Muran, J. (2000). <i>Negotiating the therapeutic alliance: A relational treatment guide.</i> New York: The Guilford Publications. Chapters 2 and 3.	Safran, J. & Muran, J. (2000). <i>Negotiating the therapeutic alliance: A relational treatment guide.</i> New York: The Guilford Publications. Chapter 7.
Individual and Cultural diversity	Hays, P.A. (2008). <i>Addressing Cultural Complexities in Practice, (2nd ed).</i> Washington D.C: American Psychological Association. Chapters 1-3.	Hays, P.A. (2008). <i>Addressing Cultural Complexities in Practice, (2nd ed.).</i> Washington D.C: American Psychological Association. Chapters 4-5	Hays, P.A. (2008). <i>Addressing Cultural Complexities in Practice, (2nd ed.).</i> Washington D.C: American Psychological Association. Chapters 6-8.	Hays, P.A. (2008). <i>Addressing Cultural Complexities in Practice, (2nd ed.).</i> Washington D.C: American Psychological Association. Chapters 9-11.
Ethical Legal Standards and	American Psychological Association. (2002).	American Psychological Association. (2002). Ethical	American Psychological Association. (2002). Ethical	American Psychological Association. (2002). Ethical

Policy	<p>Ethical principles of psychologists and code of conduct.</p> <p>Johnson, B., Bacho, R., Heim, M., & Ralph, J. (2006). Multiple-Role Dilemmas for Military Mental Health Care Providers. <i>Military Medicine</i>, 171, 311-315.</p> <p>Barnett, J.E., & Johnson, W.B. (2008). Making an Ethical Decision: A Process Model. In <i>Ethics Desk Reference for Psychologists</i>. American Psychological Association.</p>	<p>principles of psychologists and code of conduct.</p> <p>American Psychological Association. (2015). Report of the Independent Reviewer. (Summary of the Investigation's Conclusions).</p> <p>American Psychological Association (2015). Council of Representatives Resolution 23B.</p>	<p>principles of psychologists and code of conduct.</p> <p>Johnson, W.B., Johnson, S.J., Sullivan, G.R., Bongar, B., Miller, L., & Sammons, M.T. (2011). Psychology In Extremis: Preventing Problems of Professional Competence in Dangerous Practice Settings. <i>Professional Psychology: Research and Practice</i>, 42, 94-104.</p>	<p>principles of psychologists and code of conduct.</p> <p>Barnett, J.E., & Johnson, W.B. (2008). Suicidal Clients. In <i>Ethics Desk Reference for Psychologists</i>. American Psychological Association.</p> <p>Jobes, D.A., Rudd, M.D., Overholser, J.C., & Joiner, T.E. (2008) Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice. <i>Professional Psychology: Research and Practice</i>, 39, 405-413.</p>
Interdisciplinary Systems	<p>Steiner, J., Ponce, A., Styron, T., Aklin, E., & Wexler, B. (2008). Teaching an interdisciplinary approach to the treatment of chronic mental illness: Challenges and rewards. <i>Academic Psychiatry</i>, 32, 255-258.</p>	<p>Arredondo, P., Shealy, C., Neale, M., & Winfrey, L. L. (2004). Consultation and interprofessional collaboration: modeling for the future. <i>Journal of Clinical Psychology</i>, 60 (7), 787-800.</p>	<p>Vinokur-Kaplan, Diane (1995). Enhancing the effectiveness of interdisciplinary mental health treatment teams. <i>Administration and Policy in Mental Health and Mental Health Services Research</i>, 22(5), 521-530.</p>	<p>Yank, G., Barber, J., Hargrove, D., & Whitt, P. (1992). The mental health treatment team as a work group: team dynamics and the role of the leader. <i>Psychiatry</i>, 55, 250-264.</p>
Assessment	<p>American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of mental</i></p>	<p>American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of mental disorders</i>,</p>	<p>American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of mental disorders</i>, Fifth Edition.</p>	<p>American Psychiatric Association. (2013). <i>Diagnostic and statistical manual of mental disorders</i>,</p>

	<p><i>disorders</i>, Fifth Edition. Washington, DC: American Psychiatric Association.</p> <p>Trzepacz, P. & Baker, R. (1993). <i>The psychiatric mental status examination</i>. New York: Oxford University Press.</p>	<p>Fifth Edition. Washington, DC: American Psychiatric Association.</p>	<p>Washington, DC: American Psychological Association.</p>	<p>Fifth Edition. Washington, DC: American Psychological Association.</p>
Intervention	<p>Beck, J. (2011). <i>Cognitive therapy: Basics and beyond, 2nd Ed.</i> New York: The Guilford Press.</p>	<p>Beck, J. (2005). <i>Cognitive Therapy for Challenging Problems</i>. New York: Guilford Press.</p>	<p>Wenzel, A., Brown, G., & Beck, A. (2009). <i>Cognitive-Therapy for Suicidal Patients</i>. Washington, DC: American Psychological Association. Chapters 6-9.</p>	<p>Davis, J. (2009). <i>Treating Post-Trauma Nightmares: A Cognitive-Behavioral Approach</i>. New York: Springer Publishing Company.</p>
Consultation	<p>Stanton, M. (2010). The consultation and education competency. In M. Kenkel & R. Peterson (Eds.). <i>Competency-based education for professional psychology</i>. (pp. 143-159). Washington, DC: American Psychological Association.</p>	<p>Sears, R., Rudisill, J., & Mason-Sears, C. (2006). <i>Consultation skills for mental health professionals</i>. New Jersey: John Wiley & Sons, Inc. Part I</p>	<p>Sears, R., Rudisill, J., & Mason-Sears, C. (2006). <i>Consultation skills for mental health professionals</i>. New Jersey: John Wiley & Sons, Inc. Part II</p>	<p>Sears, R., Rudisill, J., & Mason-Sears, C. (2006). <i>Consultation skills for mental health professionals</i>. New Jersey: John Wiley & Sons, Inc. Part III</p>
Research/Evaluation	<p>Lambert, M., Okiishi, J., Finch, A., & Johnson, L. (1998). Outcome assessment: From conceptualization to implementation. In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical</i></p>	<p>Meyer, G., Finn, S., Eyde, L., Kay, G., Moreland, K., Dies, R., Eisman, E., Kubiszyn, T., & Reed, G. (2003) Psychological testing and psychological assessment: A review of evidence and issues. In A. Kazdin (Ed.), <i>Methodological issues and</i></p>	<p>Kazdin, A. (2003). Clinical Significance: Measuring whether interventions make a difference. In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research</i>. (pp. 691-710). Washington, DC: American Psychological Association</p>	<p>Kazdin, A. (2003). Methodology: general lessons to guide research. In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical research</i>. (pp. 349-367). Washington, DC: American Psychological Association.</p>

	<i>research</i> . (pp. 619-633). Washington, DC: American Psychological Association	<i>strategies in clinical research</i> . (pp. 267-345). Washington, DC: American Psychological Association.		
Supervision	Falender, C., & Shafranske, E. (2004). <i>Clinical supervision: A competency-based approach</i> . Washington, DC: American Psychological Association. Chapter 1	Falender, C., & Shafranske, E. (2004). <i>Clinical supervision: A competency-based approach</i> . Washington, DC: American Psychological Association. Chapter 2	Falender, C., & Shafranske, E. (2004). <i>Clinical supervision: A competency-based approach</i> . Washington, DC: American Psychological Association. Chapter 3-4	Beck, J., Sarnat, J., & Barenstein, V. (2008). Psychotherapy-based approaches to supervision. In C. Falender & E. Shafranske (Eds.). <i>Casebook for clinical supervision: A competency-based approach</i> . (pp. 57-96). Washington, DC: American Psychological Association.
Teaching	Kenkel, M., & Crossman, R. (2010). Faculty and administrators in professional psychology programs: Characteristics, roles, and challenges. In M. Kenkel & R. Peterson (Eds.). <i>Competency-based education for professional psychology</i> . (pp. 249-259). Washington, DC: American Psychological Association.	Avis, J., Fisher, R., and Thompson, R. (2010). <i>Teaching in lifelong learning: a guide to theory and practice</i> . England: Open University Press. Chapter 8: Learning and learners.	Avis, J., Fisher, R., and Thompson, R. (2010). <i>Teaching in lifelong learning: a guide to theory and practice</i> . England: Open University Press. Chapter 10: Practical teaching.	Avis, J., Fisher, R., and Thompson, R. (2010). <i>Teaching in lifelong learning: a guide to theory and practice</i> . England: Open University Press. Chapter 15: Reflective Practice.
Management—Administration	Yates, B. (2003). Toward the incorporation of costs, cost-effectiveness analysis, and cost-benefit analysis in clinical research. In A. Kazdin (Ed.), <i>Methodological issues and strategies in clinical</i>	Malloy, K., Dobbins, J., Ducheny, K., & Winfrey, L. (2010). The management and supervision competency: Current and future directions. In M. Kenkel & R. Peterson (Eds.). <i>Competency-based education for professional</i>	Drum, D. (1999). Management of a mental health clinic. In W. O'Donohue & J. Fisher (Eds.) <i>Management and Administration Skills for the Mental Health Professional (Practical Resources for the Mental Health Professional)</i> .	McDonnell, E., Ashley, D., Ashley, M., Long, G., Gibson, G., Sarkissian, A., Kraus, S., & Wheeler, K., (1999). Managing quality improvement and clinical outcomes in behavioral health settings: A new role

	<p><i>research.</i> (pp. 711-727). Washington, DC: American Psychological Association.</p>	<p><i>psychology.</i> (pp. 179-197). Washington, DC: American Psychological Association.</p>	<p>Oxford, UK: Academic Press.</p>	<p>for psychologists. In W. O'Donohue & J. Fisher (Eds.) <i>Management and Administration Skills for the Mental Health Professional (Practical Resources for the Mental Health Professional)</i>. Oxford, UK: Academic Press.</p>
Advocacy	<p>Lating, J., Barnett, J., & Horowitz, M. (2010). Creating a culture of advocacy. In M. Kenkel & R. Peterson (Eds.). <i>Competency-based education for professional psychology.</i> (pp. 201-208). Washington, DC: American Psychological Association.</p>	<p>DeLeon, P., Lofits, C., Ball, V. & Sullivan, M. (2006). Navigating politics, policy, and procedure: A firsthand perspective on advocacy on behalf of the profession. <i>Professional Psychology: Research and Practice</i>, 37(2), 146-153.</p>	<p>American Psychological Association Practice Organization, (2010). Health care reform: Congress should ensure that psychologists' services are key in primary care initiatives. Retrieved from http://www.apapracticecentral.org/advocacy/reform/index.aspx.</p>	<p>Myers, J., Sweeney, T., & White, E. (2002). Advocacy for counseling and counselors: a professional imperative. <i>Journal of Counseling and Development</i>, 80 (4), 394-402.</p>

APPENDIX F

Rating Scales for Didactic Questions

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Rating Scales for Didactic Questions

The content of this question addresses an important issue raised in the didactic presentation.

Strongly disagree disagree neutral agree strongly agree

This question is written in a clear and terse manner.

Strongly disagree disagree neutral agree strongly agree

Response options are well thought out and provide an appropriate level of difficulty.

Strongly disagree disagree neutral agree strongly agree

Comments: _____

APPENDIX G

Case Presentation Rating Scale

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Case Presentation Rating Form

Intern: _____ **Presentation Date:** _____ **Rater:** _____

For each of the rated categories contained on this form, use the numerical system provided below. The referent for the “Good” classification is the average intern at the end of the training year; i.e., the typical psychological practitioner who is ready to enter practice. Raters are encouraged to write comments in margins and/or at the end of this document.

- 5 Outstanding
- 4 Good
- 3 Satisfactory
- 2 Needs Improvement
- 1 Deficient

1.) Case Material:

- _____ 5 Intern presented the patient’s current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history in an unusually thorough and well organized fashion. Intern was able to skillfully integrate historic information with current symptoms to clarify the clinical picture.
- _____ 4 Intern presented the patient’s current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history thoroughly and in an organized fashion. There was evidence of integration of historic information with current symptoms.
- _____ 3 Intern presented most relevant patient information, such as current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history, but either neglected to collect some potentially valuable clinical data or provided less than fully clear symptom/data descriptions. There was only basic evidence of ability to integrate historic information with current symptoms.
- _____ 2 Intern presented most relevant patient information, but left out some key clinical/historical facts or provided vague descriptions of such. There was little evidence of intern’s ability to integrate historic information with current symptoms.
- _____ 1 Intern presented patient information in a disjointed fashion and/or either provided vague descriptions of clinical/historical facts or failed to present major symptom clusters or clinical/historical facts.

2.) Assessment of Suicide and Homicide Risks:

- _____ 5 Intern presented an unusually thorough suicide and homicide risk assessment. Presentation reflected strong knowledge of research literature on risk and protective factors for suicide and homicide. Intern formulated an exceptional crisis plan, if indicated, and appropriate protective actions were taken if necessary.

- _____ 4 Intern presented a thorough suicide and homicide risk assessment. Presentation reflected good working knowledge of the risk factors literature. Intern formulated an adequate crisis plan, if indicated, and appropriate protective actions were taken if necessary.
- _____ 3 Intern presented a basic suicide and homicide risk assessment. Presentation reflected rudimentary knowledge of research on risk factors. Intern formulated a crisis plan, if needed, but it was in need of some refinement. Appropriate protective actions were taken if necessary.
- _____ 2 Intern assessed suicide and homicide risks superficially. May have failed to ask appropriate probing questions about risk factors or failed to assess protective factors. Intern recognized the need for protective actions if indicated but may have failed to initiate the appropriate actions.
- _____ 1 Intern failed to recognize safety issues and did not assess suicidal/homicidal ideations, intent or plan.

3.) Psychological Testing: (Not applicable if intern presents a treatment case without testing)

- _____ 5 Intern skillfully selected tests to address features of the case and offered a highly sophisticated interpretation of the findings consistent with actual test data provided in summary format (e.g., test scores or scales) as part of the presentation. Presentation reflected strong knowledge of psychometric theory and the roles played by diversity issues and professional ethics in the use of psychological tests.
- _____ 4 Intern demonstrated adequate knowledge of test selection and provided an accurate interpretation of test findings consistent with actual test data provided in summary format (e.g., test scores or scales) as part of the presentation. Presentation reflected knowledge of psychometric theory and/or awareness of the roles played by diversity issues and professional ethics in the use of psychological tests.
- _____ 3 Intern demonstrated appropriate use of one or more standard psychological tests without specifying why a particular test was used. Interpretation of findings was accurate, as evident from test data presented with the case, but quite basic. Presentation reflected only rudimentary knowledge of psychometric theory and/or awareness of the roles played by diversity issues and professional ethics in the use of psychological tests.
- _____ 2 Intern referenced test findings without providing summary test scores/scales or provided summary test data but offered only a very basic interpretation. Presentation did not reflect knowledge of psychometric theory or awareness of the roles played by diversity issues and professional ethics in the use of psychological tests.
- _____ 1 Case presentation included psychological test data but interpretation was inaccurate. Presentation reflected deviation from standard practice, may have included interpretation errors due to lack of awareness of diversity issues, and/or may have included ethically questionable practices.
- _____ N/A

4.) Diagnosis:

- _____ 5 Intern demonstrated an unusually thorough knowledge of mental health classification, including relevant DSM-V diagnostic criteria, in supporting his/her diagnostic formulation. Intern was unusually thorough in consideration of relevant patient data and accurately ruled out different diagnoses.
- _____ 4 Intern demonstrated thorough knowledge of mental health classification, including relevant DSM-V diagnostic criteria, in supporting his/her diagnostic formulation. Intern considered relevant patient data to rule out different diagnoses.
- _____ 3 Intern demonstrated basic knowledge of diagnostic nomenclature and the DSM-V, and his/her diagnostic formulation appeared adequate, though symptom descriptions were not sufficiently detailed to provide overwhelming support for the diagnoses and/or facts needed to rule out other diagnoses were not presented in a thorough manner.
- _____ 2 Intern demonstrated only a rudimentary theoretical knowledge and understanding of basic diagnostic nomenclature and the DSM-V. Interns omitted a number of patient facts needed to support his/her diagnostic formulation and/or to rule out different diagnoses.
- _____ 1 Intern demonstrated significant deficits in understanding of the mental health classification system and/or ability to use DSM-V criteria to develop a diagnostic conceptualization. Intern gave the patient wrong diagnoses based on inaccurate interpretation of the DSM-V and/or inadequate data collection.

5.) Case Conceptualization: (Not applicable if intern presents a testing/assessment case rather than a treatment case)

- _____ 5 Intern produced an unusually strong case conceptualization within own preferred theoretical orientation, and was able to draw multiple insights from other orientations. Case formulation demonstrated strong knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 4 Intern produced a good case conceptualization within own preferred theoretical orientation, and was able to draw some insights from other orientations. Case formulation demonstrated knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 3 Intern produced an adequate case conceptualization within own preferred theoretical orientation. Case formulation demonstrated basic knowledge of current literature regarding preferred orientation and evidence based treatments.
- _____ 2 Intern's case conceptualization reflected some limitations in theoretical understanding of the intern's chosen orientation, and demonstrated a limited appreciation of the current literature regarding preferred orientation and evidence based treatments.
- _____ 1 Intern failed to reach a coherent case conceptualization from any orientation and was only able to report symptoms of the patient.
- _____ N/A

6.) Intervention: (Not applicable if intern presents a testing/assessment case without treatment)

- _____ 5 Intern provided a description of psychotherapy interventions that reflects a sophisticated understanding of psychological treatment. Outcome data were presented that strongly support intern's description of therapeutic effectiveness and illustrate intern's sophistication in understanding and using outcome measures.
- _____ 4 Intern provided a description of psychotherapy interventions that reflects a solid understanding of psychological treatment. Outcome data were presented that substantiate intern's description of therapeutic effectiveness and illustrate intern's awareness of the value of outcome measures.
- _____ 3 Intern provided a description of psychotherapy interventions that reflects a basic understanding of psychological treatment. Some outcome data were presented that support intern's description of therapeutic effectiveness and illustrate intern's basic awareness of the value of outcome measures.
- _____ 2 Intern provided a description of psychotherapy interventions that reflects only a very rudimentary understanding of psychological treatment. Outcome data are either not presented or are presented in a manner that does not that support intern's description of therapeutic progress.
- _____ 1 Intern provides a description of psychotherapy interventions that are inappropriate for the given case, reflect poor understanding of psychological treatment issues, or do not take into consideration outcome data.
- _____ N/A

7.) Military Issues: (Not applicable if case is not an active duty service member)

- _____ 5 Intern demonstrated an unusually thorough understanding of how demands of military service and military life impact patient's functioning and treatment options. Intern identified operational needs and military issues present in the case, and, if indicated, illustrated how he/she addressed them proactively with the patient and/or the command.
- _____ 4 Intern demonstrated good understanding of how demands of military service and military life impact patient's functioning and treatment options. Intern identified some operational needs and military issues present in the case, and illustrated how he/she addressed them at some point in the treatment process with the patient and/or the command
- _____ 3 Intern demonstrated some understanding of military issues and operational demands present in the case, but may have failed to take them into full consideration when making recommendations regarding the case.
- _____ 2 Intern demonstrated limited awareness of important military issues and demands present in the case
- _____ 1 Intern demonstrated no awareness of important military issues and demands present in the case.
- _____ N/A

8.) Interdisciplinary Functioning: (Applicable only if interdisciplinary issues are apparent for the case)

- _____ 5 Intern identified indications for consultation with other professional services and exhibited an unusually keen awareness of the value of interdisciplinary approaches to treatment.
- _____ 4 Intern identified need for consultation and initiated requests for such in a manner reflective of solid awareness of the value of interdisciplinary approaches to treatment.
- _____ 3 Intern identified need for consultation and initiated requests for such in a manner reflective of some understanding of and appreciation for the value of interdisciplinary approaches to treatment.
- _____ 2 Intern appeared to have a limited awareness of the need for consultation to other professional services, and appeared to have limited insight regarding the value of interdisciplinary approaches to treatment.
- _____ 1 Intern appeared to have no awareness of the need for consultation to other professional services, and appeared to have no understanding of the value of interdisciplinary approaches to treatment.
- _____ N/A

9.) Recommendations:

- _____ 5 Recommendations for a treatment case took into account multiple patient needs and military demands, and took into consideration cultural diversity issues. Intervention strategies recommended were evidence based and an unusually thorough treatment plan was outlined in which measureable treatment goals were specified, patient strengths and limitations were delineated, a treatment modality was identified, and estimated length of treatment was provided.

For a testing/assessment case, recommendations provided to referral sources and the patient fully addressed the referral question and took into account multiple patient's needs and military demands, and took into consideration cultural diversity issues. An unusually thorough discussion of the implications of assessment findings for prognosis and clinical management of the case was presented.
- _____ 4 Recommendations for a treatment case took into account various patient needs and military demands, and took into consideration at least one cultural diversity issue. Intervention strategies recommended were evidence based and a thorough treatment plan was outlined in which treatment goals were specified, patient strengths and limitations were delineated, a treatment modality was identified, and estimated length of treatment was provided.

For a testing/assessment case, recommendations provided to referral sources and the patient addressed the referral question and took into account several aspects of patient's needs, military demands, and cultural diversity issues. A thorough discussion of the implications of assessment findings for prognosis and clinical management of the case was presented.

_____ 3 Recommendations for a treatment case took into account patient needs and one or more military demands and/or cultural diversity issue. Intervention strategies recommended were evidence based and a treatment plan was outlined in which treatment goals were specified and a treatment modality was identified.

For a testing/assessment case, recommendations provided to referral sources and the patient addressed aspects of the referral question and took into account at least one specific patient need, military demand, or cultural diversity issue. A basic discussion of the implications of assessment findings for prognosis and clinical management of the case was presented.

_____ 2 Recommendations for a treatment case only superficially took into account patient's needs, military demands and/or cultural diversity issues. Intervention strategies recommended were not evidence based and/or a rudimentary treatment plan was outlined in which treatment goals and treatment modalities were vaguely specified.

For a testing/assessment case, recommendations provided to referral sources and the patient only marginally addressed the referral question and did not take into account specific patient needs, military demands, or/or cultural diversity issues. A very superficial discussion of the implications of assessment findings for prognosis and clinical management of the case was presented.

_____ 1 For a treatment case, inappropriate recommendations were made to the patient, his/her command, and/or referral sources. Either a treatment plan was not offered or it was clearly inadequate (e.g., recommended an inappropriate intervention for the presenting problem).

For a testing/assessment case, recommendations provided to referral sources and the patient was inappropriate and/or based on inaccurate interpretation of testing/assessment data. Either no implications of assessment findings for prognosis and clinical management are discussed and/or incorrect implications are discussed.

10.) Scholarly Review of the Literature:

_____ 5 Intern conducted a thorough literature review on a topic directly related to the case and succinctly summarized information gained from the review into a coherent report. Intern used the knowledge gained to inform treatment or to positively impact assessment conclusions in an unusually skillful manner.

_____ 4 Intern conducted a literature review on a topic directly related to the case and was able to use the knowledge gained to inform treatment or to clarify assessment conclusions.

_____ 3 Intern conducted a literature review on a topic directly related to the case but did not appear confident or skillful in translating knowledge gained from the review into practice.

_____ 2 Intern conducted a limited literature review or conducted a literature review on a topic not directly related to the case and was not able to demonstrate ability to link insights gained from the literature to treatment/assessment of this case.

_____ 1 Intern did not conduct a literature review on a topic appropriate to the case or provided a very limited or inadequate one.

11.) Ethical and Legal Issues:

- _____ 5 Intern demonstrated unusually strong knowledge of the ethical principles and military laws and regulations pertinent to the case. Intern demonstrated unusually strong judgment regarding actions to take to resolve or address ethical issues, if such were identified. Information reflected a very solid understanding of an ethical decision making model.
- _____ 4 Intern demonstrated full understanding of the ethical principles, and military laws and regulations pertinent to the case. Intern was able to specify an appropriate means to resolve ethical issues in this case, if such were identified, and the use of an ethical decision making model was apparent.
- _____ 3 Intern demonstrated some understanding of the ethical principles, and military laws and regulations pertinent to the case. If such were identified, intern offered only a vague prescription for resolving ethical issues or indicated only the need to consult with a supervisor. Either there was only vague reference to an ethical decision-making model or use of one was not well executed.
- _____ 2 Intern demonstrated only superficial awareness of potentially important ethical and legal issues present in the case, and did not discuss viable approaches to resolving ethical concerns, if any were identified. There was no indication that an ethical decision making model was being used to structure the discussion.
- _____ 1 Intern did not address ethical or legal concerns pertinent to this case.

12.) Diversity Issues:

- _____ 5 Intern demonstrated strong acknowledgement and respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Recognized when more information was needed regarding patient differences and described highly skillful processes for securing this information. The presentation reflected a sophisticated use of the ADDRESSING framework.
- _____ 4 Intern recognized individual differences with the patient, and demonstrated respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Case presentation demonstrated awareness of own limits in expertise and efforts to take diversity issues into consideration in case conceptualization/assessment and treatment planning. The presentation reflected an appropriate use of the ADDRESSING framework.
- _____ 3 Intern recognized individual differences with the patient, and was respectful of differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Intern made some efforts to take diversity issues into consideration in case conceptualization/assessment and/or treatment planning. The presentation reflected an unsophisticated use of the ADDRESSING framework.
- _____ 2 Intern demonstrated some recognition of individual differences between self and the patient but was unable to take diversity issues into full consideration when reaching case conceptualization/assessment and/or during treatment planning. The presentation did not reflect the use of the ADDRESSING framework or other model for addressing diversity issues.

_____ 1 Intern did not address individual/cultural differences between self and the patient during the case presentation.

13.) Consultation Issues:

_____ 5 Intern demonstrated a high degree of skill as per his/her descriptions of interactions with referral sources and/or military commands. Intern described processes for providing feedback to referral sources, commands and/or others involved in the treatment of the case that reflect an unusually high level of consultative skill development.

_____ 4 Intern's description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect appropriate ability to communicate recommendations.

_____ 3 Intern's description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect acceptable ability to communicate recommendations.

_____ 2 Intern demonstrated only a rudimentary knowledge of consultative processes and his/her description of interactions with referral sources, military commands, and/or others involved in the treatment of the case reflect difficulties communicating recommendations clearly.

_____ 1 Intern was either unable to communicate recommendations clearly to the patient's referral source, command, or others involved with the treatment or did not appear to appreciate the need to consult with others involved in the care of the patient when the need for such is apparent from the description of the case.

14.) Advocacy Issues:

_____ 5 Intern intervened with others on behalf of the patient to promote changes positively impacting the patient's functioning and/or wellbeing. Intern's actions fostered self-advocacy on the part of the patient and also reflected intern's awareness of the need to develop alliances with relevant individuals/groups and/or to engage groups with differing viewpoints around the issue to promote change.

_____ 4 Intern intervened with patient to promote actions on factors impacting the patient's functioning, promoted patient's self-advocacy, and/or assessed implementation and outcome of patient's self-advocacy plans.

_____ 3 Intern identified specific barriers to patient improvement (e.g., lack of transportation to mental health appointments), and assisted patient in the development of self-advocacy plans. Intern demonstrated understanding of appropriate boundaries and times to advocate on behalf of patients.

_____ 2 Intern demonstrated some awareness of social, political, economic and cultural factors that may impact on human development and functioning. Case presentation illustrated intern's knowledge of therapist as change agent outside of direct patient contact but did not detail specific advocacy actions.

_____ 1 Intern did not address advocacy issues.

15.) Administrative Issue

- _____ 5 Intern identifies an administrative issue that has a major impact on the operation of the Outpatient Mental Health Department or the unit on which the intern is currently working. Suggestions regarding possible solutions are offered that demonstrate a sophisticated understanding of business practices, program evaluation methodologies, Navy culture, and interpersonal functioning.
- _____ 4 Intern identifies an administrative issue that significantly impacts the operation of a clinic operated by the Outpatient Mental Health Department or the unit on which the intern is currently working. Suggestions regarding possible solutions are offered that demonstrate an understanding of business practices, program evaluation methodologies, Navy culture and interpersonal functioning.
- _____ 3 Intern identifies an administrative issue that impacts the operation of a clinic operated by the Outpatient Mental Health Department or the unit on which the intern is working. Suggestions regarding possible solutions are offered that demonstrate a rudimentary understanding of business practices, program evaluation methodologies, Navy culture and interpersonal functioning.
- _____ 2 Intern identifies a minor administrative issue that is in need of improvement. Suggestions regarding possible solutions are offered but do not reflect more than a superficial understanding of business practices, program evaluation methodologies, Navy culture, and interpersonal functioning.
- _____ 1 Intern identifies a trivial administrative issue that is unlikely to significantly impact the operation of the Outpatient Mental Health Department or the unit on which the intern is currently working.

16.) Use of Outcome Measures

- _____ 5 Intern provides data indicative of a consistent use of outcome measures in support of psychotherapy efforts. Intern describes factors playing a role in selection of specific measures and summarizes what he/she has learned about individual patients and about the provision of psychotherapy services as a result of collection of such data. Examples of the integration of outcome measures into base line problem definitions, treatment goal establishment, and documentation of current status/response to treatment are provided via submission of specific progress notes.
- _____ 4 Intern provides data indicative of use of outcome measures in support of psychotherapy efforts for some of their patients. Intern describes factors playing a role in selection of specific measures or summarizes what he/she has learned about individual patients and about the provision of psychotherapy services as a result of collection of such data. There is evidence that problems, treatment goals, and appraisals of current status are linked to specific outcome measures as demonstrated by presentation of specific progress notes.
- _____ 3 Intern provides data indicative of his/her ability to use outcome measures and/or a basic explanation of their appreciation for the role that such measures play in the provision of psychotherapy. Progress notes are included that illustrate the role of outcome measures in treating patients.

- _____ 2 Intern provides minimal data indicative of his/her ability to use outcome measures and/or a rudimentary explanation of their appreciation for the role that such measures play in the provision of psychotherapy.
- _____ 1 Intern provides minimal data indicative of his/her ability to use outcome measures and does not provide an explanation of their appreciation for the role that such measures play in the provision of psychotherapy.

17.) Teaching Ability:

- _____ 5 Intern's presentation suggested advanced ability to function in a teaching role; i.e., intern communicated with a high degree of effectiveness, articulated concepts in an unusually clear manner, and addressed questions in an uncommonly effective manner.
- _____ 4 Intern's presentation suggested solid ability to function in a teaching role; i.e., intern communicated effectively, articulated concepts in a clear manner, and was receptive to questions.
- _____ 3 Intern's presentation suggested basic ability to function in a teaching role; i.e., intern communicated adequately, articulated concepts in an acceptable manner, and was able to provide reasonable answers to questions.
- _____ 2 Intern's presentation suggested limited ability to function in a teaching role; i.e., intern communicated with difficulty, struggled to articulate concepts to be presented, and was only marginally effective in answering questions.
- _____ 1 Information presented during the presentation was difficult to follow and major points were poorly articulated. Responses to questions were not handled in a manner that promoted learning.

18.) Peer Consultation:

- _____ 5 Intern's comments to peers following their presentations illustrated an unusually strong ability to suggest alternative approaches to conceptualizing case material. Intern's verbal input reflected his/her high degree of awareness of the differing role functions one assumes as a consultant.
- _____ 4 Intern's comments to peers following their presentations provided a clear indication of ability to suggest alternative approaches to conceptualizing case material. Intern's verbal input reflected his/her awareness of the differing role functions one assumes as a consultant.
- _____ 3 Intern's comments to peers following their presentations provided some indication of ability to suggest alternative approaches to conceptualizing case material. Intern's verbal input reflected his/her basic awareness of the differing role functions one assumes as a consultant.

- _____ 2 Intern's comments to peers following their presentations provided only limited indications of ability to suggest alternative approaches to conceptualizing case material. Intern's verbal input reflected his/her limited awareness of the differing role functions one assumes as a consultant.
- _____ 1 Intern's comments to peers following their presentations provided no solid indication of ability to suggest alternative approaches to conceptualizing case material. Intern's verbal input did not reflect his/her awareness of the differing role functions one assumes as a consultant.

Comments: _____

APPENDIX H

Peer Perception Survey

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Peer Perception Survey Completed following the Case Presentation

Date: _____ Presenting Intern: _____ Rating Intern: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Please respond to each of the following statements using a 5-point scale where: 1 = you strongly disagree; 2 = you disagree; 3 = you neither agree nor disagree; 4 = you agree; and 5 = you strongly agree.

_____ 1.) The intern is able to convey his/her understanding of the case presented in a clear and meaningful manner.

_____ 2.) Today's presentation contained a well-constructed, concise review of the current relevant literature.

_____ 3.) The intern exhibits ability to integrate the literature review into the case conceptualization.

_____ 4.) The intern demonstrates a good understanding of ethical implications as addressed in this case presentation.

_____ 5.) The intern demonstrates a good understanding of diversity implications as addressed in this case presentation.

_____ 6.) The intern demonstrates a good understanding of consultation issues as addressed in this case presentation.

_____ 7.) The intern demonstrates a good understanding of advocacy issues as addressed in this case presentation.

_____ 8.) A strong appreciation of administrative functions is evident from the intern's presentation of an administrative issue.

_____ 9.) The intern's presentation of outcome data reflects a solid understanding of and appreciation for the role of outcome assessment in clinical practice.

_____ 10.) Consultation provided by this intern at the conclusion of my Case Presentation was very helpful and constructive.

_____ 11.) Based on this presentation, I believe this intern would make an excellent teacher.

_____ 12.) You and this intern have a satisfactory relationship as peers.

If you rate a 1 or 2 for any of the above items, please provide feedback in narrative form below:

APPENDIX I

Patient Perception Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Patient Perception Survey—Supervisor Version

Date: _____ Supervisor: _____ Intern: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

I am Dr. _____ . I am _____ (the intern)'s clinical supervisor. I would like to ask you about your impressions of _____ and the service(s) he/she has provided to you. Your responses will help me evaluate his/her performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) made it clear to you that he/she is in a training program and is under my supervision.

_____ 2.) Today (Or at your last appointment) you were seen within 15 minutes of your scheduled appointment time unless you arrived late.

_____ 3.) _____ conducted him/herself in a professional manner.

_____ 4.) It was clear to you that _____ understood you as an individual and understood your unique needs and issues.

_____ 5.) _____ fully and clearly explained recommendations for your care.

_____ 6.) _____ asked you if you had any questions about your care and if so was able to answer them to your satisfaction.

_____ 7.) _____ appeared interested and concerned about protecting your private personal information.

_____ 8.) You feel comfortable working with _____.

_____ 9.) Treatment or evaluation services provided to you by _____ have been helpful in addressing your needs.

If a patient gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Patient Perception Survey—Training Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Intern: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

I am Mr./Ms. _____]. I am the Administrative Assistant for the Psychology Internship Program. I would like to ask you about your impressions of _____ (the intern) and the service(s) he/she has provided to you. Your responses will help evaluate his/her performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____(intern) but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) made it clear to you that he/she is in a training program and is under _____ (intern's rotation supervisor) supervision.

_____ 2.) Today (Or at your last appointment) you were seen within 15 minutes of your scheduled appointment time unless you arrived late.

_____ 3.) _____ conducted him/herself in a professional manner.

_____ 4.) It was clear to you that _____ understood you as an individual and understood your unique needs and issues.

_____ 5.) _____ fully and clearly explained recommendations for your care.

_____ 6.) _____ asked you if you had any questions about your care and if so was able to answer them to your satisfaction.

_____ 7.) _____ appeared interested and concerned about protecting your private personal information.

_____ 8.) You feel comfortable working with _____.

_____ 9.) Treatment or evaluation services provided to you by _____ have been helpful in addressing your needs.

If patient gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX J

Consultation Services Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Consultation Services Survey—Supervisor Version

Date: _____ Supervisor: _____ Intern: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of referral source: _____

Source of Referral (circle one): Command Medical Officer Navy Primary Care

Manager—Physician Navy Primary Care Manager—non-Physician Specialty Clinic

Command Directed Referral Another Mental Health Provider Other: _____

I am Dr. _____. I am _____'s clinical supervisor. I would like to ask you about your impressions of the consultation services he/she recently provided for you regarding _____ (patient's name). Your responses will help me evaluate _____'s performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1—means you strongly disagree; 2—means you disagree; 3—means you neither agree nor disagree; 4—means you agree; and 5--means you strongly agree.

_____ 1.) _____ made it clear to you that he/she is in a training program and is under my supervision.

_____ 2.) _____ conducted him/herself in a professional manner.

_____ 3.) _____ provided feedback about this case in a timely manner.

_____ 4.) The feedback provided by _____ was helpful.

_____ 5.) You would feel comfortable referring patients in the future to _____.

If referral source gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Consultation Services Survey—Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Intern: _____

Patient Initials: _____ Patient's Age _____ Gender: _____ Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____ Rank: _____ Service: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of referral source: _____

Source of Referral (circle one): Command Medical Officer Navy Primary Care

Manager—Physician Navy Primary Care Manager—non-Physician Specialty Clinic

Command Directed Referral Another Mental Health Provider Other: _____

I am Mr./Ms._____. I am the Administrative Assistant for the Psychology Internship Program. I would like to ask you about your impressions of the consultation services you recently received from one of our interns, _____ (intern's name) regarding _____ (patient's name). Your responses will help evaluate _____'s (intern's name) performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____ (the intern) but will not be linked to your identity. Your responses will also be shared with our Training Committee.

I would like you to respond to each of the following statements using a 5-point scale where: 1—means you strongly disagree; 2—means you disagree; 3—means you neither agree nor disagree; 4—means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) made it clear to you that he/she is in a training program and is under _____'s (supervisor's name) supervision.

_____ 2.) _____ conducted him/herself in a professional manner.

_____ 3.) _____ provided feedback about this case in a timely manner.

_____ 4.) The feedback provided by _____ was helpful.

_____ 5.) You would feel comfortable referring patients in the future to _____.

If referral source gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX K

Interdisciplinary Team Member Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Interdisciplinary Team Member Survey: Supervisor Version

Date: _____ Supervisor: _____ Intern: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of Team Member: _____ Profession: _____

I would like to ask you a few questions about one of our interns, _____, who is currently working under my supervision and has had interactions with you as part of the _____ treatment team. Your responses will be shared with the intern but will not be linked to your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) made it clear to you that he/she is in a training program and is under my supervision.

_____ 2.) _____ clearly defined what a psychology intern is and his/her role on the treatment team.

_____ 3.) _____ conducted him/herself in a professional manner.

_____ 4.) _____ appears to understand your role and contribution to the treatment team.

_____ 5.) _____ demonstrates respect for the contributions of other disciplines to the functioning of the treatment team.

_____ 6.) _____ has made a significant contribution to the functioning of the treatment team.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Interdisciplinary Team Member Survey: Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Intern: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of Team Member: _____ Profession: _____

I would like to ask you a few questions about one of our interns, _____, who is currently working under the supervision of Dr. _____, and has had interactions with you as part of the _____ treatment team. Your responses will be shared with the intern but will not be linked to your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) _____ (the intern) made it clear to you that he/she is in a training program and is under Dr. _____'s supervision.
- _____ 2.) _____ clearly defined what a psychology intern is and his/her role on the treatment team.
- _____ 3.) _____ conducted him/herself in a professional manner.
- _____ 4.) _____ appears to understand your role and contribution to the treatment team.
- _____ 5.) _____ demonstrates respect for the contributions of other disciplines to the functioning of the treatment team.
- _____ 6.) _____ has made a significant contribution to the functioning of the treatment team.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX L

Support Staff Survey

(Supervisor and Training Administrative Assistant Versions)

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Support Staff Survey: Supervisor Version

Date: _____ Supervisor: _____ Intern: _____

Rotation (circle): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of support staff: _____

Support role (circle): Administrative support Psychiatric Technician Other: _____

I would like to ask you about your impressions of _____ (intern), who is currently working under my supervision in our Internship Training Program. Your responses will be shared with the intern but not your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) treats you with dignity and respect.

_____ 2.) _____ behaves in a professional manner.

_____ 3.) _____ understands your role within the organization.

_____ 4.) _____ utilizes your services appropriately.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Support Staff Survey: Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Intern: _____

Rotation (circle): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Initials of support staff: _____

Support role (circle): Administrative support Psychiatric Technician Other: _____

I would like to ask you about your impressions of _____ (intern), who is currently working under _____ (supervisor's name) supervision in our Internship Training Program. Your responses will be shared with the intern but not your identity. Your responses will also be shared with our Training Committee. Please be candid and truthful in your answers.

I would like you to respond to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

_____ 1.) _____ (the intern) treats you with dignity and respect.

_____ 2.) _____ behaves in a professional manner.

_____ 3.) _____ understands your role within the organization.

_____ 4.) _____ utilizes your services appropriately.

If respondent gives a 1 or 2 for any of the above items, query them as to the reasons for these ratings and record below:

APPENDIX M

Diversity Consultation Survey

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Diversity Consultation Survey

Date of Observed Supervision: _____ Intern: _____

Supervisor: _____ Diversity Liaison: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health

Rotation Sequence (circle one): 1st Rotation 2nd Rotation 3rd Rotation 4th rotation

Responses to statements below use a 5-point scale where: 1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; and 5 = strongly agree.

Regarding the intern's requests for diversity consultation with the Diversity Liaison:

_____ 1.) The intern identified a diversity issue of sufficient complexity to warrant consultation.

_____ 2.) The intern's request for diversity consultation reflected an awareness between his/her own dimensions of diversity and his/her attitudes towards diverse others.

_____ 3.) The intern's request for diversity consultation reflected a desire to use culturally relevant best practices in providing services to his/her patients.

The number of diversity consultation requests made this rotation by the intern was _____

Regarding the Diversity Liaison's observation of a supervision session:

_____ 4.) During the supervision session the intern spontaneously addressed issues of diversity in a manner that illustrated knowledge of the role of culture in interactions with diverse others.

_____ 5.) During the supervision session the intern articulated an alternative and culturally appropriate repertoire of skills, techniques, and behaviors for addressing a diversity issue.

_____ 6.) During the supervision session the intern exhibited a strong knowledge base regarding the impact of diversity issues on psychological assessment and/or treatment procedures.

The following feedback is provided for ratings of 1 or 2. _____

APPENDIX N

Military Assessment of Symptoms and Outcomes (MASO)

APPENDIX O

Peer Supervision Rating Form

Naval Medical Center Portsmouth Internship Training Program 2015-2016

Peer Supervision Rating Form

Date: _____ Peer Supervisor: _____ Rater: _____

Please indicate whether you are:

Peer Supervisee: _____ Transrotational Supervisor: _____ Training/Asst Training Director: _____

Please rate the quality of peer supervision by responding to each of the following statements using a 5-point scale where: 1--means you strongly disagree; 2--means you disagree; 3--means you neither agree nor disagree; 4--means you agree; and 5--means you strongly agree.

- _____ 1.) Peer Supervisor provided a sense of acceptance and support.
- _____ 2.) Peer Supervisor established clear boundaries.
- _____ 3.) Peer Supervisor provided both positive and corrective feedback to the supervisee.
- _____ 4.) Peer Supervisor helped the supervisee conceptualize the case.
- _____ 5.) Peer Supervisor raised cultural and diversity issues relevant to the case.
- _____ 6.) Peer Supervisor offered practical and useful case-centered suggestions.
- _____ 7.) Peer Supervisor assisted the supervisee in integrating different techniques.
- _____ 8.) Peer Supervisor conveyed active interest in helping supervisee grow professionally.
- _____ 9.) Peer Supervisor maintained appropriate and useful level of focus in supervision.
- _____ 10.) Peer Supervisor was respectful of differences in culture, ethnicity or other individual diversity between supervisor and supervisee.

If any of the above items is given a 1 or 2, please explain the reasons for these ratings below:

APPENDIX P

Outpatient Supervision Contract

SUPERVISION CONTRACT:
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Outpatient Rotation I & II

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Drs. _____, hereafter referred to as supervisors. The purpose of this supervision contract is to explain the learning activities and supervision processes for the outpatient training rotations I & II. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Two, three month, rotations fall within the outpatient treatment setting. This rotation takes place primarily at the Adult Mental Health Clinic of NMCP but also will include the chance to practice at one of the local branch mental health clinics.. This document defines the roles of intern and supervisors, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of each three-month segment of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of outpatient psychology clinics. From 60 to 70% of the intern's time will be spent in direct clinical service and interdisciplinary activities. The NMCP outpatient clinic is located within an Outpatient Mental Health Clinic, which houses a number of mental health specialties, including neuropsychology, health psychology, and child mental health, along with the general adult outpatient clinic. The hospital also has several smaller branch clinics staffed by multidisciplinary teams. At all training sites the intern will have the opportunity to work in collaboration with psychology sub-specialists in addition to other mental health professionals, primary care managers and medical specialty providers. The intern will be supervised in the performance of psychological assessments and interventions for the treatment of military personnel, family members of military members, and military veterans who present with a broad range of acute and chronic mental health problems (e.g. mood disorders, adjustment disorders, trauma-related issues, psychotic disorders, and relational and occupational problems). This rotation facilitates the development of psychological assessment skills and psychotherapy based on psychological theory and research, and emphasizes evidence based treatment

modalities. The intern will have opportunities to demonstrate skills and experience in diagnostic interviewing, psychological testing, treatment planning, short-term psychotherapy and interdisciplinary team participation. In addition, the intern will be exposed to military-specific activities such as security screenings and fitness-for-duty evaluations.

There will be rotation-specific reading assignments appropriate for both training sites, which will be individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison will participate in at least one supervision session held at NMCP to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisors throughout the rotation.

The intern will have a designated supervisor at all training sites and between the two supervisors the intern will receive a minimum of three hours face to face supervision each week. The intern will also receive one hour of face to face supervision per week from his/her Transrotational Evidence-Based Therapy supervisor. Under no circumstances will the intern receive fewer than 4 hours of supervision any given week and a minimum of 2 of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours from each training site are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the outpatient supervisors will be so advised by the Training Director and between the Training Director and the supervisors a plan will be developed and implemented to make-up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisors' backgrounds and clinical competencies germane to practice within the outpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the specific treatment settings.
- Opportunity to observe supervisors performing no fewer than 2 outpatient diagnostic interviews at each training site.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.

- The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate, or obtain assistance for, the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner, or the intern poses a threat to self or others.
- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
 - Timely completion of supervision-related administrative procedures.
 - Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (e.g., Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats as provided in each treatment setting.

- Completion of all clinical documentation within 72 hours of service delivery, which includes final entry of evaluations and progress notes into the electronic medical record.
- Availability of audio or videotaped recordings of all clinical sessions with patients, unless otherwise instructed by supervisors.
- Openness and receptivity to feedback.
- Maintenance of draft and final reports of all case materials within the intern's folder on the appropriate computer share drive for patients seen at NMCP.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol, as per each training site, in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

At the end of the Outpatient I and II rotations competency ratings are made, independently, by the NMCP outpatient supervisor, and the intern's Transrotational supervisor as described in the Training Manual. Levels of competency development expected at the end of these rotations are outlined in the Competency Assessment Rating Scale, which is contained in the program's Training Manual. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se, nor are rotations repeated when performance is subpar. An intern obtaining ratings at or above "Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings fall below the minimally acceptable level, as defined in the training manual, will be placed in a remedial status and provided with a remedial plan. Remedial plans target specific performance deficiencies and outline measures designed to assist the intern in over-coming performance/competency obstacles. If the remedial plan does not bring an intern

up to expected competency levels by the next rating period, the intern may be given a second period of remediation or, conversely, at the recommendation of the Training Committee may be referred to the Graduate Medical Education Committee, which could result in the intern's placement on Command Probation. The intern's rights to due process are strictly maintained throughout this process.

_____ Date: _____
Psychology Intern

_____ Date: _____
NMCP Rotation Supervisor

APPENDIX Q

Inpatient Supervision Contract

SUPERVISION CONTRACT:
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Inpatient Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____, hereafter referred to as supervisor. The purpose of this supervision contract is to explain the learning activities and supervision processes for the inpatient training rotation. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Additionally, this document defines the roles of intern and supervisor, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of an inpatient psychiatry unit. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The intern will attend and participate in morning team meetings, interview new patients, develop/monitor treatment/discharge plans, provide individual therapy/crisis intervention, participate in group therapy, and conduct psychological testing as needed. The intern will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated mental health services. The intern will also consult with family members and the commands of active duty service members to make decisions regarding military disposition. One day per week over the course of the rotation will be spent in didactic presentations, providing therapy to transrotational patients, and receiving supervision for transrotational cases.

The inpatient rotation will be conducted on psychiatric units 5-E and/or 5-F of Building 2 of NMCP. Unit 5-E provides intensive inpatient psychiatric treatment for severe Axis I psychiatric illnesses and Unit 5-F provides intensive inpatient psychiatric treatment for dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus an Axis I or Axis II psychiatric disorder). These units serve active duty patients and a lesser number of adult family members. The intern will function as a treatment team member who is assigned a small caseload

for whom he/she is responsible for coordinating team treatment planning, consulting with family members and military commands, and providing individualized therapy and assessment services. The intern will also be responsible for providing group therapy four times per week to the psychiatric units. In addition, the intern will be on call with psychiatric residents for emergency room psychiatric consultations 10 times over the course of the rotations. Five of these will be overnight shifts, and five will be from 1600-2200. The work day typically starts at 0800 and extends beyond 1630 as needed.

There will be rotation-specific reading assignments, which are individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison may participate in at least one supervision session to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisor throughout the rotation.

The supervisor will provide a minimum of one hour of individual supervision each week. The intern will also receive one hour of supervision per week from his/her Transrotational Evidence-Based Therapy supervisor and two or more hours of group supervision from rotation supervisor and/or the attending psychiatrist on the unit, who is an adjunct supervisor for the internship program. Under no circumstances will the intern receive fewer than four hours of supervision any given week and a minimum of two of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the supervisor will be so advised by the Training Director and between the two of them a plan will be developed and implemented to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisor's background and clinical competencies germane to practice within the inpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the inpatient units.
- Opportunity to observe supervisor leading inpatient groups, if needed.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.

- The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.
- **The Availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
 - Timely completion of supervision-related administrative procedures.
 - Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (i.e., Portfolios, Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats.

- Completion of all clinical documentation as required within the psychiatric inpatient settings. In most instances documentation must be entered into the inpatient electronic medical record on the same day of service.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the inpatient rotation supervisor and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development required of the program. In the event that either member of this Competency Committee provides a rating that falls below the minimally acceptable level, a third rater/supervisor is added to the Competency Committee and the average of three supervisor ratings is used as the competency metric for each competency domain. Supervisors included as the third rater will have direct exposure to the intern's work by providing coverage supervision in the absence of the rotation supervisor. Recorded interviews and therapy sessions, plus written work samples, will be the same as those rated by the primary supervisor, and third raters will have attended the intern's case presentation. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se. An intern obtaining ratings at or above "Minimally Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings are lower than that level will be placed on a remedial status. This information will be discussed with the intern and plans will be made at that time to remediate any deficiencies. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on

Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

_____ Date: _____
Psychology Intern

_____ Date: _____
Rotation Supervisor

APPENDIX R

Health Psychology, Primary Care Rotation Supervision Contract

SUPERVISION CONTRACT
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Health Psychology: Primary Care Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____, hereafter referred to as supervisor. The purpose of this supervision contract is to explain the learning activities and supervision processes for the outpatient training rotation. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Additionally, this document defines the roles of intern and supervisor, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of an outpatient primary care clinic. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The rotation will provide the intern the opportunity to work in collaboration with primary care managers (PCMs). During the outpatient primary care rotation the intern will be supervised in the performance of brief behavioral assessments and interventions for the treatment of military personnel and family members who present with a broad range of medical and behavioral/mental health problems (e.g. sleep disturbances, pain, obesity, stress, mood disorders, adjustment disorders and trauma-related issues). The intern will develop skills in structured brief diagnostic interviewing, interventions and recommendations, evidenced based cognitive-behavioral psychotherapy and learn about psychotropic medications. An appointment is approximately 25-30 minutes and patients generally attend 1-4 appointments. Brief behavioral health measures will routinely be used during this rotation to assess patient symptoms. Finally, the intern may be exposed to military-specific activities such as brief fitness-for-deployment assessments.

There will be rotation-specific reading assignments, which will be focused on the Behavioral Health Integration Program in the Medical Home Port. Additional readings will be

individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison may participate in at one supervision session to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisor throughout the rotation.

The supervisor will provide a minimum of 2 hours face to face supervision each week. The intern will also receive 1 hour face to face supervision from the pain psychology supervisor and one hour of face to face supervision per week from his/her Transrotational Evidence-Based Therapy supervisor. Under no circumstances will the intern receive fewer than 4 hours of supervision any given week and a minimum of 2 of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the supervisor will be so advised by the Training Director and between the two of them a plan will be developed and implemented to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisor's background and clinical competencies germane to practice within the outpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the outpatient primary care clinic.
- Opportunity to observe supervisor performing no fewer than 2 outpatient primary care diagnostic interviews.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose

personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.

- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (i.e., Portfolios, Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation as required within the outpatient primary care setting. In most instances documentation must be entered into the electronic medical record on the same day of service.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.

- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the primary care rotation supervisor, the pain psychology rotation supervisor, and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development required of the program at this stage of the intern's training. In the event that either member of this Competency Committee provides a rating that falls below the minimally acceptable level, a fourth rater/supervisor is added to the Competency Committee and the average of three supervisor ratings is used as the competency metric for each competency domain. Supervisors included as the third rater will have direct exposure to the intern's work by providing coverage supervision in the absence of the rotation or transrotational supervisor. Recorded interviews and therapy sessions, plus written work samples, will be the same as those rated by the primary supervisor, and third raters will have attended the intern's case presentation. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se. An intern obtaining ratings at or above "Minimally Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings are lower than that level will be placed on a remedial status. This information will be discussed with the intern and plans will be made at that time to remediate any deficiencies over the course of the next rotation. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

_____ Date: _____
Psychology Intern

_____ Date: _____
Rotation Supervisor

APPENDIX S

Health Psychology, Pain Psychology Rotation Contract

SUPERVISION CONTRACT
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Health Psychology: Pain Psychology Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____ (and Dr. _____, if there are two supervisors), hereafter referred to as supervisor(s). The purpose of this supervision contract is to explain the learning activities and supervision processes for the outpatient training rotation. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Additionally, this document defines the roles of intern and supervisor, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of an outpatient primary care clinic. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The rotation will provide the intern the opportunity to work in collaboration with psychiatrists, physical therapists, surgeons, and anesthesiologists. During the pain psychology rotation the intern will be supervised in the performance of assessments and interventions for the treatment of military personnel and family members who present with chronic pain conditions and co-morbid psychological distress. The intern will provide cognitive-behavioral individual and group therapy for chronic pain.

There will be rotation-specific reading assignments, which will be focused on the assessment and treatment of chronic pain. Additional readings will be individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison may participate in one supervision session to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisor throughout the rotation.

The supervisor will provide a minimum of 1 hour face to face supervision each week. The intern will also receive 2 hours face to face supervision from his/her primary care supervisor and one hour of face to face supervision per week from his/her Transrotational Evidence-Based Therapy supervisor. Under no circumstances will the intern receive fewer than 4 hours of supervision any given week and a minimum of 2 of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the supervisor will be so advised by the Training Director and between the two of them a plan will be developed and implemented to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisor's background and clinical competencies germane to practice within the outpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the outpatient pain psychology clinic.
- Opportunity to observe supervisor performing no fewer than 2 outpatient chronic pain diagnostic interviews.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.
- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**

- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (i.e., Portfolios, Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation as required within the outpatient pain psychology setting.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the pain psychology rotation supervisor, the primary care rotation supervisor and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development required of the program at this stage of the intern's training. In the event that either member of this Competency Committee provides a rating that falls below the minimally acceptable level, a fourth rater/supervisor is added to the Competency Committee and the average of three supervisor ratings is used as the competency metric for each competency domain. Supervisors included as the fourth rater will have direct

exposure to the intern's work by providing coverage supervision in the absence of the rotation or transrotational supervisor. Recorded interviews and therapy sessions, plus written work samples, will be the same as those rated by the primary supervisor, and fourth raters will have attended the intern's case presentation. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se. An intern obtaining ratings at or above "Minimally Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings are lower than that level will be placed on a remedial status. This information will be discussed with the intern and plans will be made at that time to remediate any deficiencies over the course of the next rotation. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

_____ Date: _____
Psychology Intern

_____ Date: _____
Rotation Supervisor

_____ Date: _____
Second Rotation Supervisor

APPENDIX T

Child/Family Supervision Contract

SUPERVISION CONTRACT
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Child/Family Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____ (and Dr. _____, if there are two supervisors), hereafter referred to as supervisor(s). The purpose of this supervision contract is to explain the learning activities and supervision processes for the outpatient training rotation. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Additionally, this document defines the roles of intern and supervisor, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of an outpatient primary care clinic. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The rotation will provide the intern the opportunity to work in collaboration with psychiatrists, pediatricians, and schools. The rotation prepares the intern to provide assessment, intervention and consultation with families of active duty service members. Interns will develop skills in the areas of intake processing, psychological evaluation/assessment, individual, group and/or family therapy, and in consultation with primary medical care providers, commands and local school districts. The rotation emphasizes responding to the unique challenges military families face. Through a co-therapist training model, interns will learn Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for disruptive behavior and attachment problems in preschool-age children. The intern will also learn to provide Child-Adult Relationship Enhancement (CARE) groups to parents who are patients in Outpatient Mental Health to mitigate the effects of their mental health problems on their parenting. Additional groups provided in this clinic include anger management, anxiety, parenting skills, and DBT for adolescents. Other opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate. The intern

will primarily be supervised by a child psychologist but will also have the opportunity to work with psychiatrists and licensed clinical social work staff.

There will be rotation-specific reading assignments, which will be focused on the assessment and treatment of children and adolescents. Additional readings will be individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison may participate in one supervision session to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisor throughout the rotation.

The supervisor will provide a minimum of 2 hours face to face supervision each week. The intern will also receive one hour of face to face supervision per week from his/her Transrotational Evidence-Based Therapy supervisor. Under no circumstances will the intern receive fewer than 4 hours of supervision any given week and a minimum of 2 of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the supervisor will be so advised by the Training Director and between the two of them a plan will be developed and implemented to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisor's background and clinical competencies germane to practice within the outpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the outpatient pain psychology clinic.
- Opportunity to observe supervisor performing no fewer than 2 outpatient chronic pain diagnostic interviews.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or

obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.

- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (i.e., Portfolios, Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation as required within the outpatient pain psychology setting.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the rotation supervisor(s) and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development required of the program at this stage of the intern's training. In the event that either member of this Competency Committee provides a rating that falls below the minimally acceptable level, a third rater/supervisor is added to the Competency Committee and the average of three supervisor ratings is used as the competency metric for each competency domain. Supervisors included as the third rater will have direct exposure to the intern's work by providing coverage supervision in the absence of the rotation or transrotational supervisor. Recorded interviews and therapy sessions, plus written work samples, will be the same as those rated by the primary supervisor, and third raters will have attended the intern's case presentation. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se. An intern obtaining ratings at or above "Minimally Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings are lower than that level will be placed on a remedial status. This information will be discussed with the intern and plans will be made at that time to remediate any deficiencies over the course of the next rotation. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

_____ Date: _____
Psychology Intern

_____ Date: _____
Rotation Supervisor

_____ Date: _____
Second Rotation Supervisor

APPENDIX U

Assessment Supervision Contract

SUPERVISION CONTRACT
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Assessment Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____ (and Dr. _____, if there are two supervisors), hereafter referred to as supervisor(s). The purpose of this supervision contract is to explain the learning activities and supervision processes for the outpatient training rotation. As with all our rotations, the learning activities are broad and encompass the Foundational and Functional competencies as set forth in the Internship Training Manual. Additionally, this document defines the roles of intern and supervisor, and clarifies expectations each may have for one another. The training activities specified in this document are consistent with the goals of the training program as outlined in the Internship Training Manual and are part of an integrated and coordinated sequence of learning experiences designed to prepare the intern for entry into practice as a clinical psychologist. Given that the intern is preparing for service as a Navy psychologist, there will be some military-specific features of this training experience but professional competencies emphasized during this rotation are sufficiently broad to generalize to professional practice in diverse mental health settings.

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. This rotation allows the intern to develop and express clinical competencies within the context of an outpatient primary care clinic. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The intern will evaluate cases referred for general psychodiagnostic testing from various inpatient and outpatient mental health care providers from throughout the medical center. More specifically, a number of patient referrals will be for neuropsychological evaluation for a variety of medical conditions to include traumatic brain injury, which will be seen over the course of the rotation. The intern, under supervision, will have an opportunity to learn certain test instruments, which are used in a neuropsychological evaluation, administer, and interpret these tests. The interns will discuss results with the supervisor and participate in feedback sessions with the patient (under supervision) and referral sources. The intern's training rotation will be four-tiered:

- Clinical interview (Neuropsychological (medical-based) Interview)
- Test introduction and administration

- Report writing
- Clinical feedback

The intern will also have the opportunity to participate in interdisciplinary committees on an ad hoc basis. Additionally, interns may participate in facilitating psychoeducation and therapy groups. These groups are usually composed of patients with mTBIs who are selected to participate in BTRIP, which is a two week intensive outpatient therapy program of Warrior Recovery Service.

There will be rotation-specific reading assignments, which will be focused psychodiagnostic assessment. Additional readings will be individualized based on training needs and the intern's specific interests. In addition, during the course of the rotation, the program's Cultural Diversity Liaison may participate in one supervision session to provide consultation on diversity issues related to a case. The Cultural Diversity Liaison will remain available to consult with intern and supervisor throughout the rotation.

The supervisor will provide a minimum of 2 hours face to face supervision each week. The intern will also receive one hour of face to face supervision per week from his/her Transrotational Evidence-Based Therapy supervisor. Under no circumstances will the intern receive fewer than 4 hours of supervision any given week and a minimum of 2 of these hours will be provided on an individual basis by a licensed psychologist who is either designated as a supervisor or adjunct supervisor by the Internship Training Program. Also, all psychologists providing supervision will bear clinical responsibility for the cases seen under their supervision. Supervision hours are monitored each week and in the unexpected event that the minimum number of hours of supervision is not achieved, the supervisor will be so advised by the Training Director and between the two of them a plan will be developed and implemented to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the supervisor's background and clinical competencies germane to practice within the outpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are peculiar to the outpatient pain psychology clinic.
- Opportunity to observe supervisor performing no fewer than 2 outpatient chronic pain diagnostic interviews.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the intern will voice disagreements and differences of opinion.

- Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.
- **The availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The Supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Completion of all required program elements (i.e., Portfolios, Self-Studies, Case Presentations, attendance to didactics, etc.)
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation as required within the outpatient pain psychology setting.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.

- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the rotation supervisor(s) and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development required of the program at this stage of the intern's training. In the event that either member of this Competency Committee provides a rating that falls below the minimally acceptable level, a third rater/supervisor is added to the Competency Committee and the average of three supervisor ratings is used as the competency metric for each competency domain. Supervisors included as the third rater will have direct exposure to the intern's work by providing coverage supervision in the absence of the rotation or transrotational supervisor. Recorded interviews and therapy sessions, plus written work samples, will be the same as those rated by the primary supervisor, and third raters will have attended the intern's case presentation. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se. An intern obtaining ratings at or above "Minimally Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings are lower than that level will be placed on a remedial status. This information will be discussed with the intern and plans will be made at that time to remediate any deficiencies over the course of the next rotation. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

_____ Date: _____
Psychology Intern

_____ Date: _____
Rotation Supervisor

_____ Date: _____
Second Rotation Supervisor

APPENDIX V

Transrotational Evidence Based Therapy Supervision Contract

SUPERVISION CONTRACT:
2015-2016 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Transrotational Evidence-Based Therapy

Start Date: _____

Completion Date: On or about _____

This is an agreement between _____, hereafter referred to as intern, and Dr. _____, hereafter referred to as supervisor. The purpose of this supervision contract is to explain the learning activities and supervision processes for the Transrotational Evidence-Based Therapy experience, which lasts the duration of the training year. This document defines the roles of intern and supervisor, and clarifies expectations each may have for one another.

The training program's goals, and thus this training experience's goals, are the development of professional competencies as a clinical psychologist. While this training activity lasts the entire year (though you may elect to change supervisors after six months and enter into another supervision agreement for the remainder of the training year), performance will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document at the end of each quarter when interns switch primary rotations. Over the course of the Transrotational Evidence-Based Therapy training experience the intern will develop and exhibit clinical competencies by providing empirically validated psychological interventions to patients with various mental health conditions in an outpatient setting. The intern can expect to follow 1-3 therapy cases each week over the course of the training year under the supervision of his/her Transrotational supervisor. Cases are seen and supervised within the Psychology Outpatient Clinic in Building 3 on each Tuesday of the training year, along with participation in the didactics program, with the other four days of the week devoted to one of the four primary rotations. In addition, the Transrotational supervisor may assign specific readings based on the intern's training needs and specific interests.

The Transrotational supervisor will provide at least one hour of face to face individual or group supervision each week, while the intern receives three hours of face to face supervision per week from his/her primary rotation supervisor. In the event that supervision cannot be provided by the Transrotational supervisor, the Transrotational supervisor will work with the primary rotation supervisor and the Training Director to develop and implement a plan to make up the missed supervision in a timely manner.

The intern may expect the following as part of the supervisory process:

- A sharing of the Transrotational supervisor’s background and clinical competencies germane to practice within an outpatient military mental health clinic.
- Respect for cultural, diversity, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
 - Open communication and two-way feedback.
 - The expectation that the intern will voice disagreements and differences of opinion.
 - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.
- **The Availability of the supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.
- Communication of coverage assignments for supervision when the supervisor is away from the work setting.

The supervisor may expect from _____ [the intern] the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Regular use of one or more outcome measures for each case.
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation within 72 hours of service delivery, which includes final entries into the electronic medical record.
- Provision of audio or video taped sessions when requested by supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisor responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisor bears liability in supervision and thus it is essential that the intern share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- **An understanding that the intern must follow proper clinic protocol in the case of an emergency, including immediate notification of supervisor, independent of scheduled supervision times, whenever patient safety is in jeopardy.**

Performance Evaluation:

As outlined in the Training Manual, evaluation of competency attainment at the end of each quarter of the training year is evaluated by the intern's Competency Committee, which is comprised of the Transrotational supervisor, listed below, plus the intern's primary rotation supervisor(s). Expected and minimally acceptable levels of competency development are outlined in the Training Manual, as are specific evaluation processes/procedures.

_____ Date: _____
Psychology Intern

_____ Date: _____
Transrotational Supervisor

APPENDIX W

Weekly Supervision Form

Intern Weekly Supervision Summary Form

Rotation: _____
 Dates of Scheduled Supervision: _____
 Duration of Scheduled Individual Supervision: _____
 Duration of Scheduled Group Supervision: _____
 Supervisor: _____ Intern: _____

<i>Unscheduled Supervision</i>		
<i>Day of Week</i>	<i>Face to Face Individual Hours</i>	<i>Face to Face Group Hours</i>
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

CONTENT SOURCE: (Check all that apply for the entire week, including unscheduled supervision activities)

- | | |
|--|--|
| <input type="checkbox"/> Intern description of case | <input type="checkbox"/> Outcome data reviewed |
| <input type="checkbox"/> Supervisor's observation of assessment/ therapy session | <input type="checkbox"/> Audio Available |
| <input type="checkbox"/> Supervisor's observation of team/referral source consultation | <input type="checkbox"/> Audio Reviewed |
| <input type="checkbox"/> Observation of Supervisor by intern | <input type="checkbox"/> Video Available |
| <input type="checkbox"/> Observation of Adjunct Supervisor by intern | <input type="checkbox"/> Video Reviewed |
| <input type="checkbox"/> Discussion of scholarly material relevant to case | <input type="checkbox"/> Other: _____ |

MEDICAL RECORD DOCUMENTATION REVIEWED THIS WEEK:

Yes No

COMPETENCIES ADDRESSED DURING WEEK'S SCHEDULED AND UNSCHEDULED SUPERVISION (Percent of total Supervision time with no units smaller than 5%)

- | | |
|--|--|
| 1) <input type="checkbox"/> Professionalism | 9) <input type="checkbox"/> Intervention |
| 2) <input type="checkbox"/> Reflective practice/Self-Assessment
Self-Care | 10) <input type="checkbox"/> Consultation |
| 3) <input type="checkbox"/> Scientific Knowledge and/Methods | 11) <input type="checkbox"/> Research/Evaluation |
| 4) <input type="checkbox"/> Relationships | 12) <input type="checkbox"/> Supervision |
| 5) <input type="checkbox"/> Individual and Cultural Diversity | 13) <input type="checkbox"/> Teaching |
| 6) <input type="checkbox"/> Ethical Legal Standards and Policy | 14) <input type="checkbox"/> Management-Administration |
| 7) <input type="checkbox"/> Interdisciplinary Systems | 15) <input type="checkbox"/> Advocacy |
| 8) <input type="checkbox"/> Assessment | Total: <input type="checkbox"/> (100%) |

POSITIVE FEEDBACK PROVIDED TO INTERN:

No Yes, as follows: _____

CONSTRUCTIVE FEEDBACK PROVIDED TO INTERN:

No Yes, as follows: _____

ISSUES PERTAINING TO THE SUPERVISORY RELATIONSHIP DISCUSSED:

No Yes, as follows: _____

Supervisor _____ Intern _____

APPENDIX X

Listing of Intern Didactic Topics

2015-2016 Intern Didactic Topics

- I. Orientation Didactics: Orientation didactics include an introduction to Navy psychology, instruction on clinical documentation, guidance on risk assessment and safety planning, an introduction to Barnett and Johnson's Ethical Decision Making Model, a didactic on common legal issues and proceedings (given by the hospital JAG), and an introduction to APA's Guidelines on Multicultural Education Training, Research, Practice and Organizational Change for Psychologists.
- II. Mental Status Examinations: A series of two didactics addressing mental status examinations as covered in Trzepacz and Baker's text, *The Psychiatric Mental Status Examination*.
- III. Organizational Development: One didactic on an organizational development topic is usually presented each month. Topics may include: Consultations/Resource Utilization, Command-Directed Evaluations, Special Forces, IA Deployments, Overseas Psychology, Psychiatric SPRINT missions, Psychological/Psychiatric Status Related to Aviation and Other Specialized Duties, VA Psychology and DOD Collaboration, 706 Boards, and Navy Executive Medicine.
- IV. Cognitive Therapy: A series of six didactics presented by Dr. Barbara Cubic of Eastern Virginia Medical School. Required Text is Judith Beck's *Cognitive Therapy: Basics and Beyond, 2nd Ed.*
- V. Cognitive Therapy for Depression: A 2.5-day workshop by the Center for Deployment Psychology that provides an in-depth training on a manualized CBT treatment for depression in service members and veterans.
- VI. Prolonged Exposure Therapy: A 2-day workshop by the Center for Deployment Psychology that provides in-depth training in Prolonged Exposure Therapy for PTSD.
- VII. Self-Awareness and Effective Mental Health Care: A series of 4 didactics.
- VIII. Ethical Decision Making: A series of 2 didactics using Barnett and Johnson's Ethical Decision Making Model to examine ethical dilemmas in various areas of clinical and military psychology.
- IX. Addressing Cultural Complexities in Practice: A series of 4 didactics focused on becoming a culturally responsive provider. Required text is Hays' *Addressing Cultural Complexities in Practice, 2nd Ed.*

- X. Assessment: A series of 3 didactics in which interns will learn about the MMPI-2-RF, the MCMI-III, and assessment of malingering.
- XI. Evaluating Therapeutic Outcomes: A single didactic that discusses outcome assessment and use of outcome measures.
- XII. Competency-Based Clinical Supervision: A single didactic that introduces interns to Falender's competency-based model of clinical supervision.
- XIII. Specialized content areas: Didactics interspersed throughout the training year. Topics may include health psychology, psychological intervention for chronic pain, psychopharmacology, family therapy, and others.
- XIV. Center for Deployment Psychology Workshop--All interns in military internship programs are required to attend a 5-day workshop sponsored by the Center for Deployment Psychology, which is held in Bethesda, MD. This workshop addresses multiple military- and clinically-specific aspects of deployment experiences the interns can expect to have during the time they spend in active duty military service. Detailed information can be found at <http://www.deploymentpsych.org/military>.
- XV. Substance Misuse Treatment within a Military Treatment Setting—all interns attend a five-day orientation course provided by the Substance Abuse Rehabilitation Program located on the grounds of this medical center. Though primarily didactic in nature, this course will also afford the intern opportunities to participate in diagnostic interviews of substance abusing individuals, as well as participate in group treatment offerings.

APPENDIX Y

Intern Didactic Evaluation Form

Intern Didactic Evaluation Form

Date: _____
 Topic: _____
 Presenter: _____
 Length of presentation (in hours): _____
 Intern: _____

Please indicate your rating of this presentation in the categories below by circling the appropriate number, using the 5-point scale described below.

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly Agree

1. The presenter was a good source of information. 1 2 3 4 5
2. Presenter demonstrated expertise and competence in the subject. 1 2 3 4 5
3. Material was presented in a clear and orderly fashion. 1 2 3 4 5
4. Material was presented at a level and in a manner that facilitated my learning. 1 2 3 4 5
5. Presenter responded adequately to questions and other needs of the audience. 1 2 3 4 5
6. Group discussion and other aspects of this experience, aside from the speaker's ability, further enhanced my learning. 1 2 3 4 5

INDICATE THE EXTENT TO WHICH EACH OF THE COMPETENCIES LISTED BELOW WAS ADDRESSED DURING THIS PRESENTATION, INCLUDING DISCUSSION BY ATTENDEES (Percent of total presentation time with no units smaller than 5%)

- | | |
|---|--|
| 1) _____ <i>Professionalism</i> | 9) _____ <i>Intervention</i> |
| 2) _____ <i>Reflective practice/Self-Assessment
Self-Care</i> | 10) _____ <i>Consultation</i> |
| 3) _____ <i>Scientific Knowledge and/Methods</i> | 11) _____ <i>Research/Evaluation</i> |
| 4) _____ <i>Relationships</i> | 12) _____ <i>Supervision</i> |
| 5) _____ <i>Individual and Cultural Diversity</i> | 13) _____ <i>Teaching</i> |
| 6) _____ <i>Ethical Legal Standards and Policy</i> | 14) _____ <i>Management-Administration</i> |
| 7) _____ <i>Interdisciplinary Systems</i> | 15) _____ <i>Advocacy</i> |
| 8) _____ <i>Assessment</i> | Total: __ (100%) |

APPENDIX Z

Intern's Evaluation of Supervisor

Intern's Evaluation of Supervisor for the _____ Rotation

Intern: _____

Supervisor: _____

Rotation (circle): 1st 2nd 3rd 4th

NOTE: Please rate your supervisor on the following criteria.

1. Supervisor was available at scheduled time for weekly supervision
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

2. The availability of my supervisor for unscheduled, non-emergency supervision was fully adequate
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

3. In an emergency, my supervisor was, or I feel would have been, available
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

4. My supervisor treated me with appropriate courtesy and respect
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

5. An appreciation of personal and cultural difference (i.e., opinions and ideas) was demonstrated by my supervisor
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

6. Supervisor's supervisory style positively supported my acquisition of professional competencies
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

7. Adequate feedback and direction was given by my supervisor (where needed)
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

8. Supervisor allowed me to demonstrate an appropriate level of independence
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

9. Supervisor fulfilled all supervisor responsibilities as designated in the supervision contract
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

10. I feel comfortable in the professional relationship that was established between me and my supervisor
1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Now, please rate the supervisor's ability to provide training as per the 7 Foundational and 8 Functional Competencies used to inform our training program.

- Use the following rating scale:
- 1 = Poor
 - 2 = Marginal
 - 3 = Adequate
 - 4 = Good
 - 5 = Excellent

**Foundational
Competency Domains**

**Functional
Competency Domains**

- ___ Professionalism
- ___ Reflective practice/Self-assessment
- ___ Scientific knowledge and Methods
- ___ Relationships
- ___ Individual and Cultural Diversity
- ___ Ethical Legal standards and Policy
- ___ Interdisciplinary systems

- ___ Assessment
- ___ Intervention
- ___ Consultation
- ___ Research/Evaluation
- ___ Supervision
- ___ Teaching
- ___ Management—
Administration
- ___ Advocacy

Additional Comments:

Intern

Supervisor

APPENDIX AA

Intern's End of Year Evaluation of Program

**Clinical Psychology Internship Training Program
Naval Medical Center, Portsmouth
End of Year Program Evaluation**

Intern: _____

Date: _____

Please provide feedback regarding the quality of each component of our training program. Your input is essential to our process improvement efforts. Specifically, if a program element was particularly good, please let us know. On the other hand, if a program element was poorly executed or did not substantially enhance the training mission, please communicate this to us as well. Use additional space/pages if needed. Use the following rating scale:

1.) The application process for this program was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the application process?

Where is improvement needed? _____

General Comments: _____

2.) Orientation procedures over the first week of the program were (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the orientation procedures?

Where is improvement needed? _____

General Comments: _____

3.) Overall, the NMCP Outpatient Mental Health rotation was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the NMCP Outpatient Mental Health rotation?

Where is improvement needed? _____

General Comments: _____

4.) Overall, the Inpatient Psychiatry Rotation was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the Inpatient Psychiatry Rotation?

Where is improvement needed? _____

General Comments: _____

6.) I completed the (circle one): Child/Family Assessment Health/Pain rotation.

Overall, this rotation was (circle your response).

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of this rotation?

Where is improvement needed? _____

General Comments: _____

8.) Overall, the Transrotational Evidence-Based Training Experience was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the Transrotational Evidence-Based Training Experience?

Where is improvement needed? _____

General Comments: _____

9.) The operational experience you received on an Aircraft Carrier was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of this operational experience?

Where is improvement needed? _____

General Comments: _____

10.) The operational experience you received with the Marines/SEALS was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of this operational experience?

Where is improvement needed? _____

General Comments: _____

11.) The Center for Deployment Psychology Workshop was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the Center for Deployment Workshop operational experience?

Where is improvement needed? _____

General Comments: _____

12.) The Substance Abuse experience was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the Substance Abuse experience?

Where is improvement needed? _____

General Comments: _____

11.) The quality of clinical supervision you received over the course of the training year was, overall (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of the clinical supervision you received?

Where is improvement needed? _____

General Comments: _____

12.) Didactic Presentations you received over the course of the year were, overall (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

List the best didactic presentations you received this year.

List the worst or least useful didactic presentations you received this year.

What are your recommendations for improving the Didactics program?

13.) Your opportunities to interact with peers over the course of the training year were (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

List the best aspects of your opportunities to interact with peers.

List the most difficult aspects regarding your opportunities to interact with peers.

What are your recommendations for improving opportunities for peer interaction?

14.) The availability of strong professional role models over the course of the training year was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the most important things you learned from the professional role models you encountered in this program?

Did you observe aspects of poor role modeling? If so, please discuss your observations.

What are your recommendations for improving the programs ability to offer positive role models for our trainees?

15.) The adequacy of support services you received from the Outpatient Mental Health Department over the course of the year was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

What were the best aspects of support services offered to you this year?

Where is improvement needed? _____

General Comments: _____

Now, please rate the program's ability to provide training as per the 7 Foundational and 8 Functional Competencies used to inform our training program.

- Use the following rating scale:
- 1 = Poor
 - 2 = Marginal
 - 3 = Adequate
 - 4 = Good
 - 5 = Excellent

**Foundational
Competency Domains**

- ___ Professionalism
- ___ Reflective practice/Self-assessment
- ___ Scientific knowledge and Methods
- ___ Relationships
- ___ Individual and Cultural Diversity
- ___ Ethical Legal standards and Policy
- ___ Interdisciplinary systems

**Functional
Competency Domains**

- ___ Assessment
- ___ Intervention
- ___ Consultation
- ___ Research/Evaluation
- ___ Supervision
- ___ Teaching
- ___ Management--
Administration
- ___ Advocacy

Overall, you would rate this training program as (please circle your response):

- 1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent

Signature

Date

APPENDIX BB

Program Outcomes Assessment and Monitoring Questionnaire

Clinical Psychology Internship Training Program
Psychology Section(128Y00A)
Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197

Program Outcomes Assessment and Monitoring Questionnaire

Name: _____

Date: _____

Year and month you completed training at NMCP: Year: _____ Month: _____

Are you currently employed on a full-time basis as a clinical psychologist?

Yes

No

If yes, what is your current job title and where do you work. _____

If no, please describe your current employment status. _____

Are you currently licensed as a clinical psychologist? Yes No

If yes, in what state(s) and when were you granted licensure (year/month)? _____

If no, why are you not licensed? _____

Are you currently listed in the National Register? Yes No

If yes, when? _____

If no, are you planning to be listed? Yes No

Are you a member of APA? Yes No

If yes, to which divisions do you belong? _____

If no, are you planning to become a member? Yes No

Do you belong to other professional organizations? Yes No

If yes, which ones? _____

If no, are you planning to become a member of a professional organization?
 Yes No

Have you achieved ABPP status? Yes No

If yes, in what area? _____

If no, are you currently in the process of seeking ABPP status? Yes No

Have you had a manuscript accepted for publication in a peer-reviewed journal over the past year? Yes No

If yes, how many manuscripts and in what journals? _____

If no, do you plan to submit a manuscript within the next year for publication?
 Yes No

Have you given a presentation at a regional, national or international professional conference over the past year? Yes No

If yes, how many paper presentations and what conferences? _____

If no, do you plan to present a paper at a professional meeting within the next year?
 Yes No

Have you engaged in clinical supervision of an unlicensed or junior colleague over the past year?
 Yes No

If yes, how many total hours of direct supervision have you provided over the past year? _____

If no, do you anticipate functioning as a clinical supervisor at some point over the coming year? ___ Yes ___ No

Have you engaged in teaching activities (e.g., given lectures, presented at Grand Rounds, etc.) over the past year? ___ Yes ___ No

If yes, briefly describe your teaching activities. _____

If no, do you anticipate engaging in teaching activities over the coming year?
___ Yes ___ No

Have you been responsible for administrative tasks linked to your role as a clinical psychologist over the past year? ___ Yes ___ No

If yes, briefly describe your administrative duties. _____

If no, do you anticipate having administrative duties over the coming year?
___ Yes ___ No

How many hours have you spent over the past year attending continuing education (CE) programs/activities? _____

Please list the topics covered in the CE offerings you have attended.

Have you been presented any awards or received special recognition for your work as a psychologist over the past year?

___ Yes ___ No

If yes, please describe: _____

Below you will find a list of the 15 training objectives established for your internship program. These objectives correspond to the 7 Foundational and 8 Functional competencies around which our training program is designed. Please rate your current self-assessed competencies in these training objectives relative to your competency levels at the end of internship. Also rate the relevance of these competencies to your current professional practice and to your appraisal of their likely relevance to your professional practice in the future. The scales for these ratings are presented below.

Current Competency to competency level at end of training year	Relevance of training to current professional practice	Anticipated relevance relative to future professional practice
1 = greatly diminished	1 = not at all relevant	1 = not at all relevant
2 = diminished	2 = minimally relevant	2 = minimally relevant
3 = unchanged	3 = relevant	3 = relevant
4 = improved	4 = very relevant	4 = very relevant
5 = greatly improved	5 = highly relevant	5 = highly relevant

Training Objective	Current Competency	Relevance to Current Practice	Anticipated Relevance to Future Practice
1. Professionalism —The intern will: 1.) demonstrate the ability to continually monitor and independently resolve situations that challenge professional values and integrity; 2.) consistently conduct self in a professional manner across all settings; 3.) independently accept personal responsibility across settings and contexts; 4.) independently act to safeguard the welfare of others; and 5.) demonstrate a consolidation of professional identity as a psychologist exhibited by being knowledgeable about issues central to the field and demonstrating evidence of integration of science and practice	Please circle the appropriate rating	Please circle the appropriate rating	Please circle the appropriate rating
	1	1	1
	2	2	2
	3	3	3
	4	4	4
2. Reflective Practice/Self-Assessment/Self-Care —The intern will: 1.) demonstrate reflectivity in the context of professional practice; 2.) exhibit accurate self-assessment of competence in all competency domains, and integrate such with practice; and 3.) engage in self-monitoring of issues related to self-care	5	5	5
	1	1	1
	2	2	2
	3	3	3
	4	4	4

and in prompt interventions when disruptions occur.	5	5	5
3. Scientific Knowledge and Methods —The intern will: 1.) independently apply scientific methods to practice; 2.) exhibit knowledge of core science; and 3.) demonstrate knowledge and understanding of scientific foundations independently applied to practice.	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5
4. Relationships —The intern will: 1.) Develop and maintain effective relationships with a wide range of clients, colleagues, organizations and communities; 2.) manage difficult communications with advanced interpersonal skills; and 3.) will exhibit an effective command of language and ideas.	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5
5. Individual and Cultural Diversity —The intern will: 1.) independently monitor and apply knowledge of self as a cultural being in assessment, treatment, and consultation; 2.) independently monitor and apply knowledge of others as cultural beings in assessment, treatment, and consultation; 3.) independently monitor and apply knowledge of diversity in others as cultural beings in assessment, treatment, and consultation; and 5.) apply knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity.	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5
6. Ethical Legal Standards and Policy —The intern will: 1.) exhibit routine command and application of the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession; 2.) demonstrate a	1	1	1
	2	2	2
	3	3	3

<p>commitment to integration of ethics knowledge into professional work; and 3.) independently and consistently integrate ethical and legal standards with all foundational and functional competencies.</p>	<p>4 5</p>	<p>4 5</p>	<p>4 5</p>
<p>7. Interdisciplinary Systems—The intern will: 1.) exhibit a working knowledge of multiple and differing worldviews, professional standards, and contributions across contexts and systems, plus intermediate level knowledge of common and distinctive roles of other professionals; 2.) demonstrate beginning, basic knowledge of and ability to display the skills that support effective interdisciplinary team functioning, such as communicating without jargon, dealing effectively with disagreements about diagnosis or treatment goals, supporting and utilizing the perspectives of other team members; 3.) demonstrate skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation; and 4.) develop and maintain collaborative relationships over time despite differences.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>8. Assessment—The intern will: 1.) independently select and implement multiple methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context; 2.) independently understand the strengths and limitations of diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning; 3.) independently select and administer a variety of assessment tools and integrate results to accurately evaluate presenting question appropriate to the practice site and broad area of practice; 4.) utilizes case formulation and diagnosis for</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>

<p>intervention planning in the context of stages of human development and diversity; 5.) independently and accurately conceptualize the multiple dimensions of the case based on the results of assessment; 6.) communicate results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner.</p>			
<p>9. Intervention—The intern will: 1.) apply knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences; 2.) exhibit the ability to engage in independent intervention planning, including conceptualization and intervention planning specific to case and context; 3.) exhibit clinical skills and judgment demonstrated by ability to develop rapport and relationships with a wide variety of clients; use of good judgment about unexpected issues, such as crises, use of supervision, and confrontation in effectively delivering interventions; 4.) implement interventions with fidelity to empirical models and flexibility to adopt where appropriate; and 5.) evaluate treatment progress and modify planning as indicated, even in the absence of established outcome measures.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>10. Consultation—The intern will: 1.) exhibit ability to determine situations that require different role functions and shift roles accordingly; 2.) demonstrate knowledge of and ability to select contextually sensitive means of assessment/data gathering that answer consultation referral question; 3.) Apply knowledge to promote effective assessment feedback and to articulate appropriate recommendations; and 4.) apply literature to provide effective consultative services (assessment and intervention) in most routine and some complex cases.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>

<p>11. Research/Evaluation (Secondary Competency)—The intern will: 1.) demonstrate a general understanding of processes needed in the generation of knowledge; and 2.) exhibit the ability to evaluate outcome measures.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>12. Supervision (Secondary Competency)—The intern will: 1.) exhibit an understanding of the complexity of the supervisory role including ethical, legal, and contextual issues; 2.) demonstrate knowledge of procedures and practices of supervision by identifying goals and tasks of supervision; 3.) exhibit knowledge of the supervision literature and of how clinicians develop into skilled professionals; 4.) exhibits knowledge about the impact of diversity on all professional settings and supervision participants; 5.) demonstrates ability to participate in the supervisory process via peer supervision; and 6.) evidence a command of and application of relevant ethical, legal, and professional standards and guidelines relevant to supervision.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>13. Teaching (Secondary Competency)—The intern will: 1.) exhibit knowledge of outcome assessment of teaching effectiveness; and 2.) demonstrate the ability to apply teaching methods in multiple settings.</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>	<p>1 2 3 4 5</p>
<p>14. Management-Administration (Secondary Competency)—The intern will: 1.) participate in the management of direct delivery of professional services and respond appropriately in the management hierarchy; 2.) will exhibit</p>	<p>1 2 3</p>	<p>1 2 3</p>	<p>1 2 3</p>

awareness of principles of policy and procedures manual for organizations, programs or agencies, plus awareness of basic business, financial and fiscal management issues; 3.) will recognize own role in creating policy, and in participating in system change and management structure; and 4.) exhibit ability to develop and offer constructive criticism and suggestions regarding management and leadership of the organization.	4	4	4
	5	5	5
15. Advocacy (Secondary Competency)—The intern will: 1.) intervene with client to promote action on factors impacting development and functioning; and 2.) promote change to enhance the functioning of individuals.	1	1	1
	2	2	2
	3	3	3
	4	4	4
	5	5	5

An over-arching goal of our training program was to inculcate a desire to engage in professional activities that foster lifelong learning and ongoing development of professional competencies. Please indicate the extent to which you have engaged in activities over the past year that demonstrates your life-long learning initiatives according to the foundational and functional competencies around which we structured your training year. Please check the statement that most accurately reflects your activities over the past year.

Foundational Competencies

- Professionalism: I have not engaged in new activities in this competency domain this year
 My engagement in new activities in this competency domain this year has been limited
 I have engaged in several new activities in this competency domain this year
 I have engaged in multiple new activities in this competency domain this year
 I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

**Reflective Practice/
Self-Assessment/
Self-Care**

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

**Scientific Knowledge
and Methods**

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Relationships

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Individual and Cultural Diversity

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Ethical Legal Standards and Policy

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Interdisciplinary

Systems

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Functional Competencies

Assessment

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Intervention

- I have not engaged in new activities in this competency domain this year
- My engagement in new activities in this competency domain this year has been limited
- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Consultation** I have not engaged in new activities in this competency domain this year
 My engagement in new activities in this competency domain this year has been limited
 I have engaged in several new activities in this competency domain this year
 I have engaged in multiple new activities in this competency domain this year
 I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Research/
Evaluation** I have not engaged in new activities in this competency domain this year
 My engagement in new activities in this competency domain this year has been limited
 I have engaged in several new activities in this competency domain this year
 I have engaged in multiple new activities in this competency domain this year
 I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Supervision** I have not engaged in new activities in this competency domain this year
 My engagement in new activities in this competency domain this year has been limited

- I have engaged in several new activities in this competency domain this year
- I have engaged in multiple new activities in this competency domain this year
- I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Teaching**
- I have not engaged in new activities in this competency domain this year
 - My engagement in new activities in this competency domain this year has been limited
 - I have engaged in several new activities in this competency domain this year
 - I have engaged in multiple new activities in this competency domain this year
 - I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Management-Administration**
- I have not engaged in new activities in this competency domain this year
 - My engagement in new activities in this competency domain this year has been limited
 - I have engaged in several new activities in this competency domain this year
 - I have engaged in multiple new activities in this competency domain this year
 - I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

- Advocacy**
- I have not engaged in new activities in this competency domain this year
 - My engagement in new activities in this competency domain this year has been limited
 - I have engaged in several new activities in this competency domain this year
 - I have engaged in multiple new activities in this competency domain this year
 - I have been quite active this year engaging in activities linked to this competency domain.

Please list several activities in which you have engaged this year that reflect a commitment to lifelong learning in this competency domain.

Overall, how satisfied are you with the training you received at Naval Medical Center Portsmouth in regard to its value in preparing you for continued professional growth and development over the course of your career?

- Extremely Satisfied
- Very Satisfied
- Satisfied
- Neither Satisfied nor Dissatisfied
- Dissatisfied
- Very Dissatisfied
- Extremely Dissatisfied

Overall, how satisfied are you with the training you received at Naval Medical Center Portsmouth in regard to its value in preparing you to meet emerging issues and changes in the practice of professional psychology?

- Extremely Satisfied
- Very Satisfied
- Satisfied
- Neither Satisfied nor Dissatisfied
- Dissatisfied
- Very Dissatisfied
- Extremely Dissatisfied

Thank you for completing this questionnaire

APPENDIX CC

2015/2016 Application Form

Clinical Psychology Internship Training Program
Psychology Section (128Y00A)
Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197

Application for 2015/2016 Training Year

This form is designed to be completed as a Microsoft Word document. You should enter all of your responses in the text boxes supplied. They will expand to accommodate your text as needed.

Personal Information

Name: Last/First, MI:

Other Names you have used:

Home Address:

Work Address:

Best Phone Number to reach you during the day:

Fax Number:

Email:

Graduate Program Information

Graduate Program Name:

Department Name:

University/Institution Name:

Training Director's Name:

Training Director's Telephone Number:

Training Director's Email:

Complete Mailing Address for contacting your Training Director:

What degree will you earn upon completion of all degree requirements?

Describe your undergraduate education (e.g., schools attended, degrees earned, major fields of study, honors awarded):

Does your graduate program require a comprehensive or qualifying examination? (place X in appropriate box)

No

Yes

If yes, please explain where you are in this process (e.g., passed on a specified date, scheduled to take exam, failed exam once) and provide dates where applicable:

Does your program require a research project or dissertation? (place X in appropriate box)

No

Yes

If yes, please list the topic/title of your project, briefly explain the nature of the project (e.g., literature review, use of existing data base, empirical research), precisely describe where you are in this process (e.g., proposal approved, data collected, successfully defended) and provide dates where applicable. Please note that you will be expected to complete your dissertation prior to the completion of the internship year.

Please complete the following table summarizing your clinical training experiences (i.e., clerkships, practica) since beginning graduate studies in clinical psychology. **YOU SHOULD ONLY RECORD HOURS SPENT PROVIDING SERVICES TO ADULTS AND ALL SUPERVISION HOURS SHOULD ALSO REFLECT SUPERVISION OF ADULT CASES**

Name of facility	Dates of training	Total hours spent at facility providing direct patient care services	Total number of hours of individual supervision by licensed supervisor	Total number of hours of group supervision by licensed supervisor	Total number of hours of supervision by unlicensed supervisors

Total = Total = Total = Total =

Please list other experiences you have had that you believe have helped you in your development as a clinical psychologist (e.g., experiences with child/adolescent cases, volunteer activities, undergraduate work-studies programs).

The remainder of this application is oriented around seven Foundational and eight Functional dimensions of professional competency as delineated by Fouad, et. al. (2009) in their manuscript entitled *Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels*. Each competency is described and then followed by the delineation of essential features and benchmarks corresponding to the “readiness for internship training” developmental level. These descriptions are followed by specific requests for information or questions for you to answer. Your responses should be comprehensive yet concise and to the point. If you have not fully addressed some of these competency areas up to this point in your training, you should refer to experiences you expect to have between now and the beginning of internship training that will address the relevant issues.

Foundational Competencies

1. Professionalism: Professional values and ethics as evidenced in behavior and comporment that reflects the values and ethics of psychology, integrity, and responsibility

Essential Component A. Integrity-Honesty, personal responsibility and adherence to professional values: Work as psychologist-in-training infused with adherence to professional values; Recognizes situations that challenge adherence to professional values

Behavioral Anchor: Demonstrates knowledge of professional values; Demonstrates adherence to professional values; Identifies situations that challenge professional values, and seeks faculty/supervisor guidance as needed; Demonstrates ability to share, discuss and address, failures and lapses in adherence to professional values with supervisor/faculty as appropriate

Please describe the most important experiences you have had that have impacted your sense of professionalism, as outlined above under essential feature A.

Essential Component B. Deportment: Professionally appropriate communication and physical conduct, including attire, across different settings

Behavioral Anchor: Demonstrates awareness of the impact behavior has on client, public and profession; Utilizes appropriate language and demeanor in professional communication; Demonstrates appropriate physical conduct, including attire, consistent with context

Please describe the most important experiences you have had that have impacted your sense of deportment, as outlined above under essential feature B.

Essential Component C. Accountability: Consistently reliable; Consistently accepts responsibility for own actions

Behavioral Anchor: Completes required case documentation promptly and accurately; Accepts responsibility for meeting deadlines; Available when "on-call"; Acknowledges errors; Utilizes supervision to strengthen the effectiveness of practice

Please describe the feedback you have received from supervisors/instructors regarding accountability issues.

Essential Component D. Concern for the welfare of others: Consistently acts to understand and safeguard the welfare of others

Behavioral Anchor: Regularly demonstrates compassion; Displays respect in interpersonal interactions with others including those from divergent perspectives or backgrounds; Determines when response to client needs takes precedence over personal needs

Please describe your actions to date as a psychology trainee that reflect your concern for the welfare of others.

Essential Component E. Professional Identity: Emerging professional identity as psychologist; Uses resources (e. g., Supervision, literature) for professional development

Behavioral Anchor: Attends colloquial, workshops, conferences; Consults literature relevant to client care

Summarize the most important experiences you have had that have impacted your sense of professional identity.

2. Reflective Practice/Self-Assessment/Self-Care: Practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and a commitment for the development of the profession

Essential Component A. Reflective Practice: Broadened self-awareness; self-monitoring; reflectivity regarding professional practice (reflection-on-action); use of resources to enhance reflectivity; elements of reflection-in-action

Behavioral Anchor: Articulates attitudes, values and beliefs towards diverse others; Recognizes impact of self on others; Self-identifies multiple individual and cultural identities; Describes how others experience him/her and identifies roles one might play within a group; Responsively utilizes supervision to enhance reflectivity; Systematically and effectively views own professional performance via videotape or other technology with supervisors; Initial indicators of monitoring and adjusting professional performance in action as situation requires

Please describe clinical training and educational experiences to date that have prepared you to engage in reflective practice, as outlined above.

Essential Component B. Self-Assessment: Broadly accurate self-assessment of competence; consistent monitoring and evaluation of practice activities

Behavioral Anchor: Self-assessment comes close to congruence with assessment by peers and supervisors; Identifies areas requiring further professional growth; Writes a personal statement of professional goals; Identifies learning objectives for overall training plan; Systematically and effectively reviews own professional performance via videotape or other technology

Describe clinical training and educational experiences you have completed that have prepared you to engage in self-assessment, as outlined above.

Essential Component C. Self -Care (attention to personal health and well-being to assure effective professional functioning): Monitoring of issues related to self-care with supervisors; understanding of the central role of self-care to effective practice

Behavioral Anchor: Worked with supervisor to monitor issues related to self-care; Takes action recommended by supervisor for self-care to ensure effective training

Please describe the most important experiences you have had that illustrate your attention to self-care issues, as outlined above.

3. Scientific knowledge and Methods: Understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affect the basis of behavior, and development across the lifespan. Respect for scientifically derived knowledge

Essential Component A. Scientific Mindedness: Values and applies scientific methods to professional practice

Behavioral Anchor: Articulates, in supervision in case conference, support for issues derived from the literature; Formulates appropriate questions regarding case conceptualization; Generates hypotheses regarding own contribution to therapeutic process and outcomes; Performs scientific critique of literature

Describe academic coursework you have completed in research methods, statistics, and the philosophy of science.

Essential Component B. Scientific Foundation of Psychology: Knowledge of core science

Behavioral Anchor: Displays intermediate level knowledge of and respect for scientific basis of behavior

Delineate academic coursework you have successfully completed in subjects addressing the core scientific bases of professional psychology.

Essential Component C. Scientific Foundation of Professional Practice:
Knowledge, understanding and application of the concept of evidence-based practice

Behavioral Anchor: A applies EBP concepts in case conceptualization, treatment planning, and interventions; Compares and contrasts EBP approaches with other theoretical perspectives and interventions in the context of case conceptualization and treatment planning.

Please describe your experiences to date in applying evidence-based practice to your clinical training activities. Indicate which evidence-based interventions you have used and the basis by which you have selected specific interventions over others. Additionally, indicate the total number of clients you have treated with an evidence-based procedure, the total hours spent providing this type of intervention, and the total number of hours received in supervision (specify individual and/or group supervision formats and indicate licensed/unlicensed status of supervisors).

4. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities

Essential Component A. Interpersonal Relationships: Performs and maintains productive and respectable relationships with clients, peer/colleagues, supervisors and professionals from other disciplines

Behavioral Anchor: Forms effective working alliance with clients; Engages with supervisors to work effectively; Works cooperatively with peers; Involved in departmental, institutional, or professional activities or governance; Demonstrates respectful and collegial interactions with those who have different professional models or perspectives

Provide a critique of the quality and range of professional interpersonal relationships you have established since beginning graduate study. Summarize the feedback you have received from clinical supervisors and others regarding this dimension of competency.

Essential Component B. Affective Skills: Negotiates differences and handles conflict satisfactorily; provides effective feedback to others and receives feedback non-defensively

Behavioral Anchor: Works collaboratively; Demonstrates active problem-solving; Makes appropriate disclosures regarding problematic interpersonal situations; Acknowledges own role in difficult interactions; Provides feedback to supervisor regarding supervisory process; Provides feedback to peers regarding peers' clinical work in context of group supervision or case conference; Accepts and implements supervisory feedback non-defensively

Describe your ability to negotiate differences and handle conflict. Additionally, describe your manner of giving feedback to others and your ability to receive such. Cite specific examples to illustrate your points.

Essential Component C. Expressive Skills: Clear and articulate expression

Behavioral Anchor: Communicates clearly using verbal, nonverbal and written skills; Demonstrates understanding of professional language

This entire application reflects your ability to communicate clearly in writing. Describe your verbal/nonverbal communication skills, and describe elements of your training that have enhanced such.

5. Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with the APA policy.

Essential Component A. Self as shaped by individual and cultural diversity (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) and context: Monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation

Behavioral Anchor: Understands and monitors own cultural identities in relation to work with others; uses knowledge of self to monitor effectiveness as a professional; Critically evaluates feedback and initiates supervision regularly about diversity issues

Describe your awareness of your own cultural identities.

Essential Component B. Others as shaped by individual and cultural diversity (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) and context: Applies knowledge of others as cultural beings in assessment, treatment, and consultation of others

Behavioral Anchor: Understands multiple cultural identities and work with others; Uses knowledge of others' cultural identity in work as a professional; Critically evaluates feedback and initiates supervision regularly about diversity issues with others

Describe the extent to which you have worked with clients from diverse backgrounds. You should be as specific as possible; e.g., describe how many hours providing what kind of service to what number of members representing each diversity group you have served.

Essential Component C. Interaction of self and others as shaped by individual and cultural diversity (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) and context: Applies knowledge of the role of culture in interactions in assessment, treatment, and consultation of diverse others

Behavioral Anchor: Understands the role of multiple cultural identities in interactions among individuals; Uses knowledge of the role of culture in interactions in work as a professional; Critically evaluates feedback and initiates supervision regularly about diversity issues with others

Describe the extent to which clinical supervision you have received to date directly addressed ICD issues.

Essential Component D. Applications based on individual and cultural context: Applies knowledge, sensitivity, and understanding regarding ICD issues to work effectively with diverse others in assessment, treatment, and consultation

Behavioral Anchor: Demonstrates knowledge of ICD literature and APA policies including guidelines for practice with diverse individuals, groups, and communities;

Demonstrates ability to address the ICD issues across professional settings and activities; Works effectively with diverse others in professional activities; Demonstrates awareness of the effects of oppression and privilege on self and others

Describe structured learning activities (e.g., formal course work and workshops) you have completed that addressed ICD issues and APA policies regarding diversity. Also, describe a situation from your clinical training experiences where you observed the effects of oppression and privilege on yourself or others.

6. Ethical Legal Standards and Policy: Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations. Advocating for the profession

Essential Component A. Knowledge of ethical, legal and professional standards and guidelines: Intermediate level knowledge and understanding of the APA Ethical Principles and Code of Conduct and other relevant ethical/professional codes, standards and guidelines; laws, statutes, rules, regulations

Behavioral Anchor: Identifies ethical dilemmas effectively; Actively consults with supervisor to act upon ethical and legal aspects of practice; Addresses ethical and legal aspects within the case conceptualization; Discusses ethical implications of professional work; Recognizes and discusses limits of own ethical and legal knowledge

Describe experiences you have had that have prepared you for ethical practice. Your response should outline structured learning experiences (e.g., formal coursework and workshops) as well as the emphasis given to ethical issues as part of your clinical supervision/practice.

Essential Component B. Awareness and Application of Ethical Decision Making: Knows and applies an ethical decision-making model and is able to apply relevant elements of ethical decision making to a dilemma

Behavioral Anchor: Uses an ethical decision-making model when discussing cases in supervision; Readily identifies ethical implications in cases and understands the ethical elements in any present ethical dilemma or question; Discusses ethical dilemmas and decision-making in supervision, staffing, presentations, practicum settings

Delineate your ethical decision making model, and describe your application of such to an ethical dilemma that arose during some aspect of your clinical training.

Essential Component C. Ethical Conduct: Knowledge of own moral principles/ethical values integrated in professional conduct

Behavioral Anchor: Articulates knowledge of own moral principles and ethical values in discussions with supervisors and peers about ethical issues; Spontaneously discusses intersection of personal and professional ethical and moral issues

Provide several examples of how your personal moral values intersect with ethical standards for psychologists. How will your own moral values impact your functioning as a psychologist?

7. Interdisciplinary systems: Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines.

Essential Component A. Knowledge of the shared and distinctive contributions of other professions: Awareness of multiple and differing worldviews, roles, professional standards, and contributions across contexts and systems, intermediate level knowledge of common and distinctive roles of other professionals

Behavioral Anchor: reports observations of commonality and differences among professional roles, values, and standards

Describe the range of other professions with which you have worked. Outline your understanding of the commonalities and differences among these professions.

Essential Component B. Functioning in multidisciplinary and interdisciplinary contexts: Beginning knowledge of strategies that promote interdisciplinary collaboration versus multidisciplinary functioning

Behavioral Anchor: demonstrates knowledge of the nature of interdisciplinary vs. multidisciplinary function and the skills that support interdisciplinary process

Describe your understanding of the difference between multidisciplinary and interdisciplinary functioning, and describe the skills you have developed that support interdisciplinary processes.

Essential Component C. Understands how participation in interdisciplinary collaboration/consultation enhances outcomes: Participate in and initiates interdisciplinary collaboration/consultation directed toward shared goals

Behavioral Anchor: consults with and cooperates with other disciplines in service of clients

Describe a particular clinical case in which your ability to provide interdisciplinary collaboration/consultation enhanced outcome.

Essential Component D. Respectful and productive relationships with individuals from other professions: Develops and maintains collaborative relationships and respect for other professions

Behavioral Anchor: communicates effectively with individuals from other professions

Estimate the percentage of your clinical training time spent within an interdisciplinary or multidisciplinary treatment context, and describe each setting. Also, describe the features of your communication style that have allowed you to function effectively in these settings.

Functional Competencies

1. Assessment: Assessment and diagnosis of problems capabilities and issues associated with individuals, groups, and/or organizations

Essential Component A. Measurement and Psychometrics: Selects assessment measures with attention to issues of reliability and validity

Behavioral Anchor: Identifies appropriate assessment measures for cases seen at practice site; Routinely consults with supervisor regarding selection of assessment measures

Provide an example of a clinical case for which your knowledge of differing psychometric properties of instruments played a role in your selection of assessment measures.

Essential Component B. Evaluation Methods: Awareness of the strengths and limitations of administration, scoring and interpretation of traditional assessment measures as well as related to technological advances

Behavioral Anchor: Demonstrates intermediate level ability to accurately and consistently select, administer, score and interpret assessment tools with client populations; Collects accurate and relevant data from structured and semi-structured interviews and minimal status exams

List the clinical tests you have administered, along with the number of administrations. Also report the extent to which you were observed by a supervisor during test administration.

Essential Component C. Application of Methods: Selects appropriate assessment measure to answer diagnostic question

Behavioral Anchor: Selects assessment tools that reflect awareness of patient populations served at a given practice site; Regularly selects and uses appropriate methods of evaluation; Demonstrates ability to adapt environment and materials according to client needs (e.g., Lighting, privacy, ambient noise)

Describe differing approaches to psychological assessment you have encountered across the training sites in which you have trained. Discuss your understanding of the reasons for such differences.

Essential Component D. Diagnosis: Applies concepts of normal/abnormal behavior to case formulation and diagnosis in the context of stages of human development and diversity

Behavioral Anchor: Articulates relevant developmental features and clinical symptoms as applied to presenting questions; Demonstrates ability to identify problem areas and to use concepts of differential diagnosis

Outline structured learning activities (e.g., formal coursework and workshops) that have provided you with a solid understanding of psychopathology. Discuss the extent to which you have received formal coursework addressing the DSM-V.

Essential Component E. Conceptualization and Recommendations: Utilizes systematic approach of gathering data to inform clinical decision-making

Behavioral Anchor: Presents cases and reports demonstrating how diagnosis is based on case material

Describe the training experiences you have received regarding interview techniques, clinical history taking, and mental status examinations. To what extent have you presented your case conceptualizations in case conferences or similar venues?

Essential Component F. Communication of Findings: Writes assessment reports and progress notes

Behavioral Anchor: Writes a basic psychological report; Demonstrates ability to communicate basic findings verbally; Reports reflect data that has been collected via interview

How many psychological reports containing test data have you completed? List the 5 most frequent diagnostic groups for whom you have provided test data. What aspect of your report writing has been given the greatest emphasis during supervision?

2. Intervention: Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations

Essential Component A. Knowledge of Interventions: Knowledge of scientific, theoretical, empirical and contextual bases of intervention, including theory, research, and practice

Behavioral Anchor: Demonstrates knowledge of interventions and explanations for their use based on EBP; Demonstrates the ability to select interventions for different problems for populations related to the practice settings; Investigates existing literature related problems and client issues;

Describe specific structured training experiences (e.g., formal coursework and workshops) you have completed that addressed specific intervention procedures from a scientific, theoretical, empirical and contextual basis.

Essential Component B. Intervention planning: Formulates and conceptualizes cases and plans interventions utilizing at least one consistent theoretical orientation

Behavioral Anchor: Articulates a theory of change and identifies interventions to change; as consistent with the AAPI; Writes understandable case conceptualization reports and collaborative treatment plans incorporating evidence-based practices

State your theoretical orientation to therapy. Describe the extent of your training in this model, including formal coursework, workshop/didactic trainings, and clinical supervision specifically linked to this theoretical model. Delineate the number of hours spent performing interventions accordingly to this model and the number of supervision hours received in support of this intervention (specify individual or group supervision). Also describe the extent to which you have: 1) observed supervisors performing this model of therapy either live or via video/audio recording, and 2) the extent to which you have been directly observed performing this intervention by supervisors.

Essential Component C. Skills: Clinical skills

Behavioral Anchor: Develops rapport with most clients; Develops therapeutic relationship; Demonstrates appropriate judgment about when to consult supervisor

Describe your approach to developing rapport with clients and your approach to forming therapeutic relationships.

Essential Component D. Intervention Implementation: Implements evidence-based interventions that take into account empirical support, clinical judgment, and client diversity (e.g., client characteristics, values, and context)

Behavioral Anchor: Applies specific evidence-based interventions; Presents case that documents application of evidence-based practice

Describe your experience in the use of evidence-based interventions, in general, and describe your approach to integrating client diversity issues into evidence-based practice.

Essential Component E. Progress evaluation: Evaluate treatment progress and modified treatment planning as indicated, utilizing established outcome measures

Behavioral Anchor: Assesses and documents treatment progress and outcomes; Alters treatment plan accordingly; Describes instances of lack of progress and actions taken in response

Provide a critique of your ability to use outcome measures to track client progress. Indicate which instruments you have used for this purpose.

3. Consultation: The ability to provide expert guidance or professional assistance in response to a client's needs or goals.

Essential Component A. Role of Consultant: Knowledge of the consultant's role and its unique features as distinguished from other professional roles such as therapist, supervisor, teacher).

Behavioral Anchor: Articulates common and distinctive roles of consultant; Compares and contrasts consultation, clinical and supervision roles

Articulate your understanding of the role of a consultant and how this role differs from clinical treatment and supervision roles.

Essential Component B. Addressing Referral Question: Knowledge of and ability to select appropriate means of assessment to answer referral questions

Behavioral Anchor: Implements systematic approach to data collection in a consultative role; Identifies sources and types of assessment tools

Describe a situation outside the realm of clinical assessment in which you implemented a systematic approach to data collection in support of a consultative task (e.g., consulting to an organization).

Essential Component C. Communication of Findings: Identifies literature and knowledge about process of informing consultees of assessment findings

Behavioral Anchor: Identifies appropriate approaches and processes for providing written and verbal feedback and recommendation to consultee.

Describe your experiences to date of providing feedback to consultees—may reference clinical or nonclinical consultation services.

Essential Component D. Application of Methods: Identifies and acquires literature relevant to unique consultation methods (assessment and intervention) within systems, clients or settings

Behavioral Anchor: Identifies appropriate interventions based on consultation assessment findings

Describe an intervention you have recommended subsequent to an act of consultation—you may refer to either a clinical or nonclinical consultation.

4. Research/Evaluation: Generating research that contributes to the professional knowledge base and/or evaluates the effectiveness of various professional activities

Essential Component A. Scientific Approach to Knowledge Generation:

Development of skills and habits in seeking, applying, and evaluating theoretical and research knowledge relevant to the practice of psychology.

Behavioral Anchor: Demonstrates understanding of research methods and techniques of data analysis; Demonstrates research and scholarly activity, which may include patients at conferences, participation in research team; Submission of manuscripts for publication; Demonstrates being a critical consumer of research

Describe your experiences in conducting psychological research. Make sure you specify your role in any collaborative projects and list any presentations at professional meetings and/or publications.

Essential Component B. Application of Scientific Method to Practice: Apply scientific methods to evaluating own practice

Behavioral Anchor: Discusses evidence based practices; Compiles and analyzes data on own clients (outcome measurement); participates in program evaluation

Describe your experiences in using evidence based treatment interventions and outcome measures.

5. Supervision: Supervision and training in the professional knowledge base and of evaluation of the effectiveness of various professional activities

Essential Component A. Expectation and Roles: Knowledge of purpose for and roles in supervision

Behavioral Anchor: Identifies roles and responsibilities of the supervisor and supervisee in the supervision process

Based on your experiences to date, what do you consider to be the major roles and responsibilities of a supervisor and also of a supervisee.

Essential Component B. Processes and Procedures: Knowledge of procedures and processes of supervision

Behavioral Anchor: Identifies goals and tasks of supervision; Tracks progress achieving goals and setting new goals

Describe coursework and other structured activities you have completed that informed you of the goals and tasks of supervision.

Essential Component C. Skills Development: Knowledge of the supervision literature and how clinicians develop to be skilled professionals

Behavioral Anchor: Successfully completes coursework on supervision; Demonstrates formation of supervisory relationship integrity theory and skills including knowledge of development, educational praxis

Describe your understanding, based on completed coursework and other training, of the process by which psychologists develop into competent clinical supervisors.

Essential Component D. Awareness of factors affecting quality: Knowledge about the impact of diversity on all professional settings and supervision participants including self as defined by APA policy; beginning knowledge of personal contribution to therapy and the supervision

Behavioral Anchor: Demonstrates knowledge of ICD literature and APA guidelines in supervision practice; Demonstrates awareness of role of oppression and privilege on supervision process

Describe the intersection of your training in diversity with training experiences in supervision. Include formal course work, workshops, and clinical experiences in this discussion.

Essential Component E. Participation in Supervision Process: Observation of and participation in supervisory process (e.g., peer supervision)

Behavioral Anchor: Reflects on supervision process, areas of strength in those needing improvement; Seeks supervision to improve performance, presenting work for feedback, and integrating feedback into performance

Describe the extent to which you have functioned in a supervisory role up to this point in your training as a psychologist. Include experience in peer supervision as well as experiences supervising technicians or persons falling below your developmental level as a psychologist.

Essential Component F. Ethical and Illegal Issues: Knowledge of and compliance with ethical/professional codes, standards and guidelines; institutional policies; laws, statutes, rules, regulations, and case law relevant to the practice of psychology and its supervision

Behavioral Anchor: Behaves ethically; Recognizes ethical and legal issues in clinical practice and supervision

Describe a specific instance where you identified an ethical or legal issue and brought it to your supervisor's attention. Describe how the issue was resolved.

6. Teaching: Providing instruction, disseminating knowledge, and evaluating acquisition of knowledge and skill in professional psychology

Essential Component A. Knowledge: Knowledge of didactic teaching strategies and how to accommodate developmental and individual differences

Behavioral Anchor: Demonstrates knowledge of one learning strategy;
Demonstrates clear communication skills

Describe structured learning activities you have completed that prepared you for effective teaching. Also, describe a learning strategy that you have applied in the provision of a didactic endeavor, and illustrate how you were able to accommodate individual and developmental differences.

Essential Component B. Skills: Application of teaching methods in multiple settings

Behavioral Anchor: Identifies and differentiates factors for implementing particular teaching methods; Demonstrates accommodation to diverse others (e.g., cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status) and context; Introduces innovation/creativity in the application of teaching method

Describe your experiences in the area of teaching and, in particular, provide examples of innovative/creative approaches you have taken.

7. Management—Administration: Manage the direct delivery of services (DDS;) and/or the administration of organizations, programs, or agencies (OPA).

Essential Component A. Management: Participates in management of direct delivery of professional services; responds appropriately in management hierarchy

Behavioral Anchor: Responds appropriately to managers and subordinates;
Manages DDS under supervision, e.g., scheduling, billing, maintenance of records;

Identifies responsibilities, challenges, and processes of management

Describe structured learning opportunities and practical experiences you have had that address some form of management within a clinical setting.

Essential Component B. Administration: Knowledge of and ability to effectively function within professional settings in organizations, including compliance with all policies and procedures

Behavioral Anchor: Articulates approved organizational policies and procedures; Completes reports and other assignments promptly; Complies with record-keeping guidelines; Demonstrates understanding of quality improvement (QI) procedures and directs delivery of services and basic management of direct services, QI procedures

List the number of organizations in which you have served as a psychology trainee at the graduate level. Describe the processes by which you have gained knowledge of the organizational policies and procedures of the most complex organizational setting in which you have functioned.

Essential Component C. Leadership: Recognition of own role in creating policy, participation in system change, and management structure

Behavioral Anchor: Articulates agency mission and purpose and its connection to goals and objectives; Implements procedures to accomplish goals and objectives

Describe an instance from your background as a psychology trainee where you discussed with a supervisor or agency representative an idea to alter policy or effect system change.

Essential Component D. Evaluation of Management and Leadership: Able to develop and prepared to offer constructive criticism and suggestions regarding management and leadership of organization

Behavioral Anchor: Identifies strengths and weaknesses of management and leadership or organization; Provides input appropriately, participates in organizational assessment

Describe any opportunities you have had during your graduate studies to participate in an organizational assessment.

8. **Advocacy:** Actions targeting the impact of social, political, economic or cultural factors to promote change at the individual (client), institutional, and/or systems level

Essential Component A. Empowerment: Uses awareness of the social, political, economic or cultural factors that may impact human development in the context of service provision

Behavioral Anchor: Identify specific barriers to client improvement, e.g., lack of access to resources; Assists client in the development of self-advocacy plans

Describe a clinical case for which you served as an advocate for one of your patients.

Essential Component B. System Change: Promotes change to enhance the functioning of individuals

Behavioral Anchor: Identifies target issues/agencies most relevant to specific issues; Formulates and engages in plan for action; Demonstrates understanding of appropriate boundaries and times to advocate on behalf of client

Describe a situation where your understanding of appropriate boundaries and timing impacted the manner in which you advocated on behalf of a patient.



Thank you for completing this application