Navy Medicine Readiness and Training Command
Naval Medical Center Portsmouth
Psychology Postdoctoral Fellowship Training Manual
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INTRODUCTION

The Directorate of Mental Health (DMH), Mental Health Department, of the Naval Medical Center, Portsmouth (NMCP), offers an American Psychological Association (APA) accredited postdoctoral fellowship in clinical psychology. The training program provides an intensive twelve-month in-service period of clinical, didactic, and leadership experiences. Our fellows are trained as "generalist" clinical psychologists to acquire a set of advanced competencies necessary for meeting the behavioral and mental health needs of active-duty service members, their families, and military retirees. Additionally, the program trainings and experiences prepare the fellows as leaders in Navy psychology. The context of clinical skill/competency development is organized around the theme of treating the service member, not only in time of conflict, but also under the stressors of a routine operational environment. Training addresses the assessment and treatment of posttraumatic stress disorder (PTSD) secondary to combat, operational, and sexual trauma, depression, chronic pain, and family issues. It also provides an orientation to severe mental health conditions requiring inpatient psychiatric treatment within a military treatment facility (MTF) and to military alcohol/substance use disorder evaluation and treatment. A unique aspect of the training experience is exposure to the practice of clinical psychology in embedded operational settings—fellows complete a minor rotation working in an embedded setting such as a locally based aircraft carrier or Fellows may have other unique opportunities such as going underway with an aircraft carrier or observing and training in advanced assessment and selection with the Marine Corps Embassy Security Guard psychologist at US Marine Corps Base, Quantico, VA. The program prepares the fellow to become a clinical leader. Clinical leadership entails competencies in providing expert consultation to other medical professionals and service members' commands, evaluating existing clinical programs, developing new programs, providing effective supervision of other practitioners, and organizing resources so that clinical and administrative objectives may be met. The targeted professional competencies combined with skills developed through prior internship experiences provides the foundation needed for practice within the military mental health system yet are sufficiently broad to prepare the fellow for advanced practice in diverse non-military clinical settings. Furthermore, this program prepares the fellow for licensure as a psychologist in the state of his/her choosing and is conducive to eventual attainment of American Board of Professional Psychology (ABPP) certification in clinical psychology. Prospective fellows must apply for and be accepted as Naval officers prior to initiating this training program. Three years of obligated service as a Navy psychologist are required beginning the year following the training year.

This fellowship is accredited by the APA as a clinical psychology postdoctoral fellowship. Inquiries regarding accreditation may be addressed to the APA'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
(202) 336-5979

THE NAVAL MEDICAL CENTER PORTSMOUTH

NMCP is a major medical center Defense Health Agency (DHA), military treatment facility (MTF), supporting the delivery of integrated and high quality health services to the military health system. NMCP is situated beside the Elizabeth River, near downtown Portsmouth, VA, across the river from the city of Norfolk, VA, and not far from the largest naval base in the world, Naval Station Norfolk, as well other major Navy, Marine Corps, Army, Air Force, and Coast Guard bases. The hospital buildings on the compound are predominant landmarks on the Portsmouth waterfront. There is a 15-deck high rise structure that was built in the early 1960's that has been extensively renovated and houses various outpatient clinics, including clinics operated by Directorate for Mental Health (DMH). Adjacent to this structure is the Charette Health Center, which was completed and occupied in 1999. This $330M, five deck, one million square foot structure is a state-of-the-art hospital. These buildings connect to the original hospital building, dating to 1827 and distinguished as the first Naval Hospital in the United States. The buildings around the hospital house support services, a residential substance use disorder program, enlisted staff living quarters, a Navy exchange, an indoor swimming pool, a superb gym, abundant parking, a consolidated food and beverage club, and various support services. In addition to the core hospital, there are 10 branch health clinics and six major military bases in the NMCP catchment, all of which are in reasonable proximity to the main hospital complex. In addition, NMCP oversees 10 local branch health clinics (BHC) and heads the multi-service market that includes the Army's medical facilities at Fort Eustis and the Air Force medical facility at Langley Air Force Base.

NMPC is a major teaching facility, with a medical transitional year physician internship program, 15 accredited medical residency and fellowship programs, with over 250 physicians in training, and American Psychological Association (APA) accredited clinical psychology internship and postdoctoral fellowship training programs. There is also accredited training programs offered for nurses, physician assistants, radiology technicians and other allied health professions. NMCP is affiliated with the Eastern Virginia Medical School (EVMS) and the Uniformed Services University of the Health Sciences (USUHS). The Hampton Veteran's Administration Hospital, Old Dominion University, Regent University, Norfolk State University, Hampton University, and Christopher Newport University are located nearby, allowing for affiliations and cross trainings with university graduate level education in both general and health care fields. As part of its commitment to health care education, the postdoctoral fellowship program has the full financial support of the Department of the Navy. The DMH also has official memorandums of understanding with the psychology doctoral programs at the Virginia Consortium and Regent University to sponsor practicum training for their psychology doctoral students.

NMCP is a principal defense health care resource that provides comprehensive care for all beneficiaries entrusted to its care. Its beneficiaries range in age from the newborn to the elderly and come from a wide range of sociocultural backgrounds. NMCP supports the national interest of the United States

through force health protection by guaranteeing patient-centered quality healthcare, maximizing service member and family readiness, and excelling in medical education and innovative research. There is an emphasis on prevention of injury and illness, and promotion of fitness and wellbeing through healthy lifestyles. The clinical issues that are common to any large teaching hospital are available for instructional 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 military assignment. In brief, NMCP offers a rich clinical training environment, plus a sincere commitment to the training of diverse health care professionals.

NMCP is located in Hampton Roads, which comprises the seven cities of Portsmouth, Norfolk, Virginia Beach, Chesapeake, Suffolk, Hampton, and Newport News. With a combined population of 1.7 million, this vibrant area is home to a diverse mix of military and civilian people.

NMCP DIRECTORATE OF MENTAL HEALTH

The DMH administratively houses the Mental Health Department, the neuropsychology and interdisciplinary TBI clinics, other specialty mental health clinics, the Substance Abuse Rehabilitation Program (SARP), and an inpatient psychiatric unit.

In concert with NMCP's missions, the DMH provides direct patient care, and prepares its staff for operational contingencies. The DMH operates an American Psychological Association (APA) accredited clinical psychology postdoctoral fellowship program and an APA accredited internship, and is an APA approved sponsor of continuing education units. The DMH hosts the larges psychiatry internship and residency program in the Navy. Through the Navy Medicine Professional Development Center (NMPDC) Continuing Medical Education (CME) Department, Bethesda, Maryland, DMH is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for Physicians. The DMH also provides training towards certification for alcohol and drug counselors.

Staff consists of uniformed (Navy and United States Public Health Service) and civilian psychologists, psychiatrists, social workers, and psychiatric nurse practitioners. The DMH's interdisciplinary mental health providers staff provides services in general outpatient mental health clinics and an inpatient psychiatric unit, as well as in subspecialty clinics in child/family psychology, substance use disorders, and neuropsychology/psychological assessment. Support personnel include active duty and civilian office managers, psychiatric technicians, psychometricians, nurse case managers, office automation clerks, and administrative assistants/training program managers for the psychology training programs and the psychiatric internship/residency program.

The majority of the DMH psychologists work at the core hospital in Portsmouth, and fellows spend most of the training year there. There is also mental health assets located throughout the surrounding geographical area in reasonable proximity to the main medical center where fellows may be afforded training opportunities. The DMH has appropriate offices/workspaces for fellows, up-to-date

computers, digital recorders, video technology, and other technological resources to carry out its training mission in all the locations it supports. The upgrading of technology is a continuous process.

AIMS OF THE TRAINING PROGRAM AND EXPECTED COMPETENCIES

The NMCP Clinical Psychology Postdoctoral Fellowship Training Program prepares diverse psychology postdoctoral fellows to function competently, effectively, and ethically in professional roles that combine clinical service and scholarly inquiry. The program aspires to prepare fellows to secure professional licensure as psychologists and to transition successfully upon completion of the program to employment as a US Naval Officer clinical psychologist who possesses competencies that are consistent with American Psychological Associate (APA) training standards and generalizable to a wide range of settings and sociocultural diverse patient populations.

The overarching aims of the NMCP Postdoctoral Fellowship Program in clinical psychology are to ensure that fellows are prepared to:

(1) Function as competent and capable generalist psychologists who engage in a broad array of evidence-based health service psychology activities.

(2) Serve as collaborative, ethical, and culturally competent team members and leaders in diverse settings and with diverse populations.

(3) Develop advanced professional competencies that allow the fellow to practice competently within the Navy/military environment (e.g., unique military populations, personnel evaluation skills, fitness for duty evaluations).

Within the constructs of these overarching aims, the postdoctoral fellowship program emphasizes the assessment and treatment of posttraumatic stress disorder (PTSD), depression,), chronic pain, child and family issues, and substance use disorders. Consultation to commands (e.g. consults to client/patient employers) and consultation with other medical and mental health disciplines are a significant aspect of the duties and responsibilities of a Navy psychologist. This clinical skill set optimally prepares our graduates for service to their country as Navy psychologists, but also prepares them to be effective clinical psychologists in other diverse settings. The program additionally prepares the fellows to assume an organizational leadership role. Clinical leadership development entails evaluating existing clinical programs, developing new programs, providing effective supervision of other practitioners, and/or organizing resources so that clinical and administrative objectives may be met. The fellows also take a lead as instructors for the Directorate Training Curriculum that includes specific trainings for clinic support staff, psychiatric technicians, nursing staff and psychiatry residents. We emphasize knowledge and proficiency regarding biopsychosocial issues that are relevant to all the above.

In accordance with our aims and in congruence with American Psychological Association, Commission on Accreditation, *Standards of Accreditation in Health Service Psychology*, the psychology postdoctoral fellowship program at NMCP's assessed competencies include the following: **1. Advanced competencies of integration of science and practice as it pertains to scientific knowledge and**

methods, assessment, intervention, research/evaluation, supervision, and teaching; 2. Individual and cultural diversity; and 3. Ethical legal standards and practice. Our program specific competencies include: **1. Consultation and advocacy as they pertain to interdisciplinary systems, consultation, relationships and advocacy; 2. Management and administration; 3. Professionalism; and 4. Reflective practice/self-assessment/self-care.**

The section below briefly describes the four major categories of **learning experiences** we employ and notes the competency(ies) addressed by each:

Delivering Direct Service - All fellows will provide direct services that provide them the opportunity to work in a professional and scientific community and establish a more integrated professional identity. The amount of time devoted to direct service in general is approximately 25 to 30 hours per week. All fellows engage in the requisite number of direct service hours required for licensure in all of the jurisdictions associated with the Association of State and Provincial Psychology Boards (ASPPB). Throughout all of these direct service activities, emphasis is placed on the development of the following competencies: **Professionalism**, **Individual and Cultural Diversity**, **Ethical and Legal Standards**, **Assessment, Treatment, Consultation, Advocacy, Research and Evaluation,** and the **Integration of Science and Practice**.

PROVIDING SUPERVISION

It is our training philosophy that supervision is a core competency within clinical psychology that deserves in-depth attention at the postdoctoral fellowship level. The supervision training provided is designed to build and enhance fellow skills in supervision through assigned reading, didactics, and supervision of supervision. Fellows will engage in a dual training role, as that of a supervisor [by providing training and supervision to the assigned psychology practicum students, when possible] and simultaneously, as that of the trainee [in their own individual supervision and by participating in Trauma Supervision and Outpatient Group Supervision with a Licensed Psychologist(s), for 2 hours/week, alongside current psychology interns].

Requirements for participation will vary depending upon the type of group supervision that the fellow is participating in. Participation might include case review via audio/video critique, and/or review of current of a research article or scholarly reading pertinent to the case that speaks to a particular evidenced based therapy, ethical-legal issue, biopsychosocial issue, or other relevant issue. Discussion of relevant clinical process issues will also occur.

Specific to the supervision competency, all fellows will read Supervision Essentials for the Practice of Competency-Based Supervision (Falender & Shafranske, 2017) and meet at least four times per year as a group with a supervisor for a reading-based discussion of providing competency-based supervision and didactics. (The Supervision Seminars).

When possible, fellow will have the opportunity throughout the training year to provide clinical supervision to a junior psychology colleague (i.e. a practicum student). Practicum students' placement at NMCP may be curtailed by organizational restrictions related to the Covid 19 pandemic. The fellow will also engage in the teaching/co-teaching and supervision of other staff members and trainees (e.g., psychiatric technicians, psychometrists, nurses, psychiatry residents, etc.), as appropriate.

In addition to weekly individual supervision sessions for the practicum trainees, the fellows will lead monthly one-hour group supervisions and additional didactics, as needed, for these students.

In accordance with best practices, fellows discuss their own supervisory activities in their own weekly supervision. Fellows are encouraged to consult the faculty member assigned as the Practicum Training Lead, for additional guidance as required. These experiences afford the fellows the opportunity to apply and practice what they learn in the program's focused competency-based supervision didactics.

The activities associated with this learning experience highlight the Supervision competency, along with the other competencies as appropriate. Emphasis will be placed on strengthening the Fellow's skills in teaching and supervision, in preparation for future clinic management and leadership.

Receiving Supervision - Intensive supervision, based upon the fellow's responsibilities and developmental needs, is a major component of the training program. All fellows receive a minimum of two scheduled individual supervision hours per week, as well as two hours of group supervision. Supervisors are always readily available for any issue that needs to be addressed. In reality, most residents will average well over the mandated four hours per week of supervision. It is explained at the onset of the training year that supervisory discussions have some important limits in terms of confidentiality. Supervisors may, on occasion, share some of the content of these discussions with other training faculty/supervisors when needed to support training, preserve quality patient care or research, or, in extreme situations, to protect the patient or public. In terms of clinical supervision, supervisory orientations differ depending on the service setting within the medical center, as well as the supervisor. Supervisor theoretical orientations include behavioral, biological, cognitive-behavioral, developmental, existential/humanistic, family systems, integrative, interpersonal, neurobiological, and psychodynamic. Clinical supervision may include, but is not limited to the following: intensive review of case material; co-therapy; live supervision; reviewing video or audio; readings; discussions of the integration of theory, research, and practice; and explorations of the self of the therapist. Fellows are invited to share personal reactions and to engage in a process of self-examination. Research supervision may include, but is not limited to the following: research team meetings, discussions of research findings, manuscript preparation, and grant preparation. When taken together, the supervision that residents receive addresses: **Integration of Science and Practice, Assessment, Intervention, Research and Evaluation, Supervision, Teaching, Individual and Cultural Diversity, Ethical and Legal Standards, Interdisciplinary Systems, Consultation, Relationships, Advocacy, Officer Development, Professionalism, and Reflective Practice/Self-Assessment/Self-Care.**

DIDACTICS AND OTHER FORMAL LEARNING EXPERIENCES

Didactics: All fellows are invited to attend weekly didactics with the psychology interns. Topics that are always covered include:

1. Orientation didactics, including an introduction to Navy psychology, ethical issues pertaining to practice in military settings, safety assessment and documentation, and fitness for military duty evaluations.(These didactics are required of all fellows)
2. Intensive didactics on cognitive-behavioral therapy from Dr. Barbara Cubic, a nationally recognized cognitive-behavioral psychologist.
3. Didactics on psychological testing covering the MMPI-2-RF, MMPI 3, the MCMI-IV, and assessment of malingering.

4. Didactics on the psychological assessment and treatment of chronic pain in military populations.
5. Didactics on substance use disorder services and treatment in the military.
6. Trainings on Prolonged Exposure and Cognitive-Processing Therapy.
7. Didactics on biopsychosocial issues presented by the program's Biopsychosocial and Ethics Liaison.
8. Didactics on self-care.
9. Didactics related to professional development and officership.

Some didactics will cover professional development issues particular to military psychologists; for example, practice in various settings, such as aircraft carriers or overseas. These didactics change year to year based on the availability of active-duty psychologists to present (active-duty psychologists usually change duty stations every three years). Professional development didactics are required of all fellows. In addition, other trainings on various therapy modalities are often offered either through NMCP or through other training institutions.

All fellows are required to attend all didactics related to officer development and military psychology. Fellows may discuss with their supervisor regarding opting out of didactics that were covered in their internship year, if applicable.

Supervision Seminars: Fellows attend supervision seminars throughout the year in which they discuss assigned readings from *Supervision Essentials for the Practice of Competency-Based Supervision* (Falender & Shafranske, 2017) in the context of their supervision of practicum students.

Psychology CE Presentations: Presentations and/or workshops of varying durations are offered through the Psychology Division's APA-approved Continuing Education sponsorship. Presentations addressing biopsychosocial issues, professional ethics, and clinical supervision are examples of the types of presentations that are included among the offerings each year.

Mental Health Grand Rounds: Weekly 1-hour presentations provided by mental health department staff and trainees.Fellows are required to attend all of these presentations over the training year and have the opportunity to present at least once, either individually or as a group. A wide range of mental health topics are addressed during these presentations. Fellows who present at Grand Rounds will be evaluated using the **Grand Rounds Presentation Rating Form** (Appendix J).

Lunch and Learn Discussion Series:

Lunch and Learn Discussion Series: Fellows, interns, and a supervisor engage in a bi-weekly discussion group devoted to biopsychosocial and ethical issues. The format will include a combination of self-assessment; thoughtful examination of relevant research, data, and theory; case study applications; multimedia presentations; and other guided discussions. On a rotating basis, trainees will lead the group discussion by presenting peer-reviewed articles on topics pertinent to their personal and professional development (topics to be approved prior to session). Care will be taken to create a safe space for challenging and thought-provoking discussions to advance trainees' knowledge, skills, and awareness in various areas of multicultural competence. The series will take place every other Friday at noon, unless

otherwise advised. Questions may be directed to the Biopsychosocial and Ethics Liaison.

Taken altogether, the formal learning opportunities described above involve all of the following competencies: **Integration of Science and Practice, Assessment, Intervention, Research and Evaluation, Supervision, Teaching, Individual and Cultural Diversity, Ethical and Legal Standards, Interdisciplinary Systems, Consultation, Relationships, Advocacy, Officer Development, Professionalism, and Reflective Practice/Self-Assessment/Self-Care.**

The program's assessment of competencies is guided by the work of Fouad and colleagues (Fouad, Grus, Hatcher, Kaslow, Hutchings, Madison, Collins, & Crossman, 2009, *Competency Benchmarks: A Model for Understanding and Measuring Competence in Professional Psychology Across Training Levels, Training and Education in Professional Psychology, 3(sup), S5-S26),* and Thomas & Hersen *Handbook of Clinical Psychology Competencies*. The competency benchmarks suggested by these authors were adapted and expanded to meet the aims of our program. The 2009 published benchmarks span three developmental levels—Readiness for Practicum, Readiness for Internship, and Readiness for Entry to Practice. In order to apply this model to our postdoctoral fellowship training program, we have expanded the developmental levels to include two additional categories—Readiness for Fully Autonomous Practice and Readiness for Life-long Learning/Master Clinician. 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.

The program uses the locally established **Competency Benchmarks for Clinical Psychology Postdoctoral Fellowship** (Appendix A) in our assessment of the fellows' competencies. Specific benchmark criteria for these developmental levels were formed by a committee of NMCP Psychology Training Program faculty members by making logical extensions of criteria provided in the published 2009 Benchmarks Document. The clinical context of training within which competencies are developed and expressed is organized around the theme of treating the service member, families, and veterans in a variety of environments, including operational formats. To this end, fellows complete one general outpatient rotation, one specialized rotation corresponding to their chosen track (i.e. Health, Child/Family, Clinical Research, or Depression/PTSD). Fellows complete one minor rotation in embedded mental health. In addition, there is an introductory (mini) experience to the Substance Addiction Rehabilitation Program (SARP) that includes training in evaluation, patient placement, treatment, and specific military alcohol and drug policy protocols. An emphasis on evidence-based practices permeates throughout the training program.

COMPETENCY ASSESSMENT RATING SCALE SYSTEM

We have chosen a competency assessment rating scale system to describe placement along the full 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 a combination of objective data, and subjective input provided by the supervisors. 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 a fellow's activities, informed by other data sources (e.g., ratings made by interdisciplinary team members, outcome data for patients seen by trainees) and render a developmentally anchored conclusion regarding trainee competence. We believe that our criterion-referenced scale has sufficient ordinal, and 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.

DESCRIPTION OF COMPETENCIES

With the above in mind, our three advanced competencies can be described as follows:

1. Integration of Science and Practice

I. **Scientific Knowledge and Methods**: Understanding of research, research methodology, techniques of data collection and analysis, biological bases of behavior, cognitive-affective basis of behavior, and development across the lifespan. Respect for scientifically derived knowledge.

The Fellow will: 1.) independently and consistently apply scientific methods to practice; 2.) Articulate advanced knowledge of core science; and 3.) Demonstrate a strong background in scientific foundations, and consistently and independently apply this knowledge to practice in a flexible manner.

II. **Assessment:** Assessment and diagnosis of problems capabilities and issues associated with individuals, groups, and/or organizations.

The fellow will: 1.) Clearly articulate a rationale for selecting and implementing differing methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups; 2.) Demonstrate advanced knowledge of administration and scoring of traditional assessment measures, models and techniques, including structured and unstructured clinical interviews and mental status exams; 3.) Independently and skillfully administer a variety of assessment tools and integrate results to accurately evaluate presenting problems and questions4.) Integrate case formulation, assessment data, and differential diagnosis into advanced intervention planning in the context of stages of human development and individual variables; 5.) Demonstrate ability to communicate results in written and verbal form with a high degree of both clarity and accuracy and in a manner appropriate to the context.

III. **Intervention:** Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations.

The fellow will: 1.) Apply advanced knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences; 2.) evidence usually strong understanding of the relationship between case conceptualization and intervention planning; 3.) Exhibit advanced helping skills; 4.) Implement interventions with both strong fidelity to empirical models and an appropriate degree of flexibility to adapt to client needs 5.) Incorporate strong understanding of intervention outcome measurement, including the following: selecting outcome measures appropriate to the case and the type of intervention; providing conceptually appropriate treatment goals even in the absence of an established outcome measure; and evaluating treatment progress and modify planning as indicated.

IV. **Research/Evaluation:** Generating and or evaluating research that contributes to the professional knowledge base and/or evaluates the effectiveness of various professional activities.

The fellow will: 1.) Exhibit an understanding of the importance of acquisition and generation of professional knowledge; 2.) Exhibit ability to evaluate outcomes of research and intervention; 3.) Independently critically evaluate and disseminate research or other scholarly activities (e.g., case conference, presentation, publications) at the local, regional, or national level; 4.) Stay abreast of the current research literature and evidence-based practices in clinical psychology; 3.) Demonstrate independent motivation to increase knowledge and expand his/her range of interventions through reading and consultation with supervisors.

V. **Supervision:** Supervision and training in the professional knowledge base and of evaluation of the effectiveness of various professional activities.

The fellow will: 1.) Understand complexity of the supervisory role including ethical, legal and contextual issues; 2.) Express knowledge of procedures and practices of supervision; 3.) engage in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients; 4.) Understand the intersecting biopsychosocial dimensions in the context of supervision practice and be able to engage in reflection on the role of self on therapy and in supervision; 5.) Provide supervision independently to others in routine cases; and 6.) Exhibit knowledge of outcome assessment of teaching effectiveness relevant to ethical, legal, and professional standards and guidelines pertaining to supervision.

VI. **Teaching:** Providing instruction, disseminating knowledge, and evaluating acquisition of knowledge and skill in professional psychology.

The fellow will: 1.) Exhibit knowledge of outcome assessment of teaching effectiveness; and 2.) Demonstrate the ability to apply teaching methods in multiple settings.

2. 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.

The fellow will: 1.) Independently and consistently monitor and apply knowledge of self as a cultural being in assessment, treatment, and consultation; 2.) Independently and consistently monitor and apply knowledge of others as cultural beings in assessment, treatment, and consultation; 3.) Skillfully apply knowledge, skills, and attitudes regarding intersecting and complex dimensions of individuality; for example, the relationship between one's own biopsychosocial dimensions and one's own attitudes towards others to professional work; and 4.) Understand military culture as it emphasizes discipline and hierarchy, prioritizes the group over the individual, and uses specific rituals and symbols to convey important meanings and transitions.

3. Ethical Legal Standards and Policy: Application of ethical concepts and awareness of legal

issues regarding professional activities with individuals, groups, and organizations.
The fellow will: 1.) Habitually utilize and apply the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession; 2.) Apply an ethical decision-making model in integrating ethics knowledge into professional work; and 3.) Resolve ethical dilemmas in a manner that aligns with to the APA Ethical Principles of Beneficence and Non-maleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity, 4.)Proactively model ethical behavior and use of ethical and legal standards.

Our four focused, program specific competencies include:

1. Consultation and Advocacy:

I. **Interdisciplinary Systems:** Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines.

The fellow will: 1.) Exhibit in depth knowledge of multiple and differing worldviews, professional standards, and contexts and systems plus advanced knowledge of common and distinctive roles of other professionals; 2.) Show comprehensive knowledge of and ability to display skills that support effective interdisciplinary team functioning, including communicating information in a clear and professional manner, assisting the team in resolving disagreements in diagnosis and treatment goals, and eliciting and using perspectives of other team members; 3.) Demonstrate advanced ability to recognize and engage in opportunities for effective collaboration with other professionals toward shared goals; and 4.) Evidence ability to develop, support, and advance collaborative relationships across time with differing disciplines.

II. **Consultation:** The ability to provide expert guidance or professional assistance in response to a client's needs or goals.

The fellow will: 1.) Skillfully determine situations that require different role functions and adeptly shift roles accordingly; 2.) Exhibit consistent ability to select appropriate and contextually sensitive means of assessment/data gathering that answers the consultation referral question; 3.) Skillfully, promptly, and effectively provide assessment feedback that demonstrates advanced knowledge and leads to highly appropriate recommendations; and 4.) Obtain and apply scientific literature to provide effective consultative services (assessment and intervention) in all routine cases and most complex cases.

III. **Relationships:** Interact effectively and meaningfully with individuals, groups, and/or communities.

The fellow will: 1.) Develop and maintain highly effective relationships with a wide range of clients, colleagues, organizations and communities; 2.) Manage difficult communication; possess clearly advanced interpersonal skills; and 3.) Exhibit articulate and eloquent command of language and ideas in communicating with others.

IV. **Advocacy:** Actions targeting the impact of social, political, economic or cultural factors to promote change at the individual (client), institutional, and/or systems level.

The fellow will: 1.) Intervene with client to promote action on factors impacting development and functioning; and 2.) Promote change at the level of institutions, community, or society.

2. Officer Development: Exhibit basic military knowledge and officership (i.e., criteria beyond professionalism as it pertains to being a uniformed services officer) and demonstrate career commitment as a Navy Psychologist.

The fellow will: 1.) Demonstrate awareness of military protocols, such as uniform, grooming standards, and demeanor, across settings and with enlisted personnel, other officers, and civilian staff members 2.) Show familiarity with regulations impacting Navy officers and health providers such as the UCMG and DOD Instructions 3.) Independently identify and work to resolve ethical issues unique to military psychology; 4.) Seek out opportunities to increase knowledge of unique aspects of Navy psychology; and 5) Be active in organizations relevant to Navy psychology.

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

The fellow will: 1.) Habitually monitor and resolve situations that challenge professional values and integrity; 2.) Be viewed by colleagues as highly professional; 3.) Be recognized as a role model for independently and consistently demonstrating personal responsibility; 4.) Demonstrate forward thinking with regard to problems; keeping the ability to safeguard the welfare of others as the foremost priority; and 5.) Exhibit full consolidation of identity as a psychologist; be broadly knowledgeable about issues central to the field; and consistently integrate science and practice.

4. Reflective Practice/Self-Assessment/Self-Care: Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care.

The fellow will: 1.) Consistently exhibit thoughtful reflection in context of professional practice (reflection-in-action); habitually act upon reflections and use self as a therapeutic tool; 2.) Exhibit accurate self-assessment of competence in all competency domains; habitually integrate self-assessment in practice; and 3.) Reliably self-monitor issues related to self-care and execute prompt interventions when disruptions occur

Expected* and Minimally Acceptable Competency Ratings

Mid-Year	End-of-Year
3.5*	**4.0***
(3.0, 3.25)**	**(3.5, 3.75)****

*** Ratings are based on consensus judgments made by the fellow's competency committee. ** The first number in parentheses specifies the minimally acceptable rating for an individual**

competency domain. The second number specifies the lowest acceptable average rating across all advanced competencies and focused, program specific competencies.

COMPETENCY ASSESSMENT TOOLKIT

The Competency Assessment Toolkit is a multifaceted approach to competency assessment is incorporated in this program. Rotation supervisors evaluate trainees at the end of each major and minor rotation. These evaluations are organized around the 3 advanced and 4 focused, program specific, competency domains. Evaluation is performed by each individual rotation supervisor in a manner outlined by the individualized **Supervision Contracts** completed for each training experience and yield judgments of Unacceptable, Marginally Acceptable, or Acceptable (Appendix B). Competency evaluations performed by the fellow's Competency Committee are conducted in the middle and again at the then end of the training year and are guided by supervisors' direct observations over the course of training, but also by examination of specific work samples and other sources of information. Specific instruments and processes used by the fellow's Competency Committee for these two evaluations are outlined below.

Mid-year and End-of-Year Competency Assessment Rating Scale: This is our primary tool for assessing fellow competency by competency committees. Using the numerical system described above (e.g., 4.00 represents readiness for entry to Fully Autonomous Practice) and referencing the **Competency Benchmarks** (Appendix A), supervisors use information obtained from direct observation plus findings from instruments/procedures described below to assign a developmental level to each assessed competency domains. All ratings are made by consensus of the Competency Committee. See (Appendix C) of this manual for a copy of this rating scale.

Competency Self-Assessment: At the beginning of the training year, at the mid-point, and at the end of the program, fellows complete a self-assessment addressing the 3 advanced and 4 focused, program specific 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 (i.e., 3.00 for Readiness for Entry to Practice) for each. The basis for each rating must also be provided. See (Appendix D) of this manual for a copy of this rating scale.

Clinical Work Samples Rating Form: Fellows maintain copies of draft reports and progress notes in an access-protected computer share drive, where they also maintain audiotapes/videotapes of their diagnostic and treatment sessions. The primary supervisor will listen to or observe live one clinical interview and one therapy session. The supervisor will also review the first draft of the accompanying documentation (intake report and 3 progress notes, one for the session under review and two additional notes from the same patient). Structured rating scales are used to evaluate the adequacy of clinical documentation and audio/video taped case samples. A specific rating tool has been developed for this material. See (Appendix E) of this manual for a copy of this rating scale.

360-Degree-like Customer Perception Surveys: Four brief survey instruments (**Patient Perception Survey, Interdisciplinary Team Member Survey, Consultation Services Survey, Support Staff Survey**) are administered prior to competency ratings performed mid-year and at the end of the year. Surveys are

administered as structured interviews to five patients, two interdisciplinary team members, two referral sources, and two support personnel. See Appendix F of this manual for a copy of this rating scale.

Case Presentation Rating Form: Two formal case presentations are required—mid-year and end- of-year. Fellows select a clinical case to present to peers and supervisors. As part of the case presentation, the fellow must summarize the findings of a focused literature review addressing an issue directly related to the clinical case being presented. This will be done in a manner that demonstrates the fellow's ability to engage in scholarly activity. Additionally, during the case presentation the fellow must address at least one ethical issue (incorporating an ethical decision-making model), biopsychosocial issues, and comment on indications for consultation and advocacy. Evidence of ability to incorporate appropriate outcome measures must also be provided. The case presentation will be evaluated using the Case Presentation Rating Scale completed by competency committee members. See Appendix G of this manual for a copy of this rating scale.

Supervision Skills Rating Form: Fellows provide supervision throughout the year to pre-doctoral trainees who are completing a practicum placement at NMCP. Three audio/video tapes from supervision sessions will be submitted for evaluation at the middle and end of the training year. A rating scale addressing the quality of supervision will be completed by both the supervised trainee and the fellow's supervisor at the mid-point and endpoint of the training year. All ratings will be examined by the fellow's competency committee prior to completing the end of year competency assessment. See (Appendix H) of this manual for a copy of this rating scale.

Weekly Clinical Supervision Forms: Fellows submit forms each week documenting supervision hours. These forms also document various aspects of the week's supervision, such as whether or not audio/video recordings of clinical work were reviewed, supervisor's direct feedback to fellows, and issues in the supervisor-supervisee relationship. Additionally, fellows and supervisors are required to denote which of the advanced competencies and program specific competencies that form the basis of our competency determinations were covered in the session. (Appendix I)

Grand Rounds Presentation Rating Form: Each fellow is permitted to present at least one Grand Round during the training year. These may be shared/group presentations. (Appendix J)

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 Training Director and forwarded to the Mental Health Department Head for review for submission to the Director of DMH. The Commanding Officer of NMCP is the reporting senior and final signatory (Appendix K).

STRUCTURE OF THE TRAINING PROGRAM

Overview: Upon entering the program fellows spend approximately two weeks completing an extensive orientation period. The orientation is designed to familiarize the fellow with the program, DMH, and the command. After the orientation period they spend one month in the Inpatient/Acute care minor rotation. This minor rotation places them on the inpatient psychiatric unit and the Emergency

Department, completing emergent evaluations and working with severe psychiatric disorders. Following this minor rotation, fellows spend the rest of the training year working within their selected training track (Mood Disorders and PTSD; Child and Family; or Health Psychology) for 6 months and spend 5 months in the General Outpatient Care rotation. General Outpatient care emphasizes seeing cases for which decisions must be made regarding military status (e.g., ability to deploy, ability to work in a particular job). In addition, this rotation emphasizes use of evidence-based therapies. While on the General Outpatient rotation, fellows will do a minor rotation in Embedded Psychology. In this minor rotation, they will spend one day a week for at least 10 weeks in an embedded setting: an aircraft carrier, the submarine squadron, or another embedded setting. They will also participate in a mini rotation experience in the Substance Addiction Rehabilitation Program (SARP). A flowchart of the training year is presented on the next page.

Throughout the training year, contingent on supervisor availability, fellows may elect to see cases that fall outside of their chosen track, such as child and family or pain cases. Additionally, fellows participate in clinical leadership activities and attend a number of didactic offerings and embedded experiences. Each fellow is assigned a primary supervisor, who, along with the Psychology Training Director and Associate Training Director, coordinates these training experiences.

Major and minor rotation supervisors, who assume clinical responsibility for the patients seen by the fellow, will each provide a minimum of one hour of scheduled, face to face individual supervision each week, for two total hours of individual supervision. Additional individual and/or group supervision will be provided in sufficient amounts to ensure sound guidance of the fellow's clinical work and adherence to APA's supervision requirements. Supervisor, with the input from the fellow, will submit on the Monday following each training week a **Weekly Clinical Supervision Form** (Appendix I) corresponding to the preceding week. At the end of this training experience, the supervisor will provide a final summary rating based upon agreements made in the **Supervision Contract** (Appendix B). The major and minor rotation supervisors provide input to the Competency Committee to determine the fellow's final rating. Specific descriptions of the program's training elements are presented after the flowchart:

Structure of the Fellowship Training Year

Orientation (all fellows): 2 weeks

Inpatient/Acute Care (all fellows): 4 weeks

Specialty Rotation: 6 months
(Mood Disorders & PTSD,
Child/Family, or Health)

General Outpatient Rotation (all fellows): 5 months

Minor rotation in Embedded Psychology, depending on interest, availability, and fellow's developmental needs(one day a week for at least 10 weeks) and mini rotation (approximately 5 days) in Substance Abuse Rehabilitation Program to take place during

ORIENTATION

The fellow begins the training year by spending approximately two weeks completing program specific, as well as hospital-wide mandated orientation and trainings (e.g., HIPPA training, Command Orientation, computerized medical record training, etc.). Fellows meet with the supervisors from all clinical rotations to review the training opportunities available with each. Fellows also meet with relevant Mental Health and NMCP leadership. This process allows time for fellows to begin to develop familiarity with the NMCP, clinical activities, record keeping, personnel issues, and procedures specific to the program. During Program Orientation, the program presents a front-load series of didactics that are designed to orient the fellow to the military mental health system, the clinic/NMCP, and to the policies of the training program. Orientation didactics include: Program Policies and Procedure—

particularly as these policies relate to performance measures, grievance policies and due process, Introduction to Navy Psychology, Clinical Resources, Safety and Assessment Documentation, Introduction to Ethical Issues in Military Psychology, Clinical Documentation, Legal Brief with the Judge Advocate General (Legal Department), and Q & A with current fellows. During the orientation period the fellow completes a detailed self-assessment addressing each of the 3 advanced and 4 focused, program specific competency domains.

TRAINING PLAN

Prior to the start of the training year, fellows will communicate with the training director to determine their specialized training track for the year (Mood Disorders and PTSD, Child and Family, or Health). Fellows will indicate their interest in the training tracks and provide supporting materials. Faculty involved in each specialty track consult with the training director to match fellows to a track. Every effort will be made to match fellows with their top preference, but there may be times in which this is not possible due to program or faculty circumstances. In the event that more fellows are interested in a track than the faculty can supervise, the strength of supporting materials will be used to determine placement. The training director will work with the fellow to determine an appropriate second choice and will strive to provide some exposure to the preferred area.

The fellows meet individually with their primary supervisors to develop a personalized training plan for the year. During the first weeks of the training year, incoming fellows complete the **Competency Self Study** (Appendix D), which is meant to serve as a self-assessment of their relative strengths and challenge areas with respect to the competencies and provide their primary supervisor with information regarding their personal goals and preferences for the training year. In addition, the fellow completes a **Supervision Contract** (Appendix B) with his or her supervisor for each major and minor rotation. The goals of the training plan are to identify needed and desired learning activities to round out the fellow's general training, to further develop fundamental clinical competencies, to address deficits in skill or experience, and to gain exposure to new patient populations and methods of assessment and intervention. Supervision contracts specify goals pertaining to the specific rotation; for example, gaining competence in providing evidence-based therapies for trauma. Supervision contracts also include specific individualized training goals that the fellows and supervisors generate together through discussion. Fellows and supervisors have significant latitude in setting these individual goals. Goals can include acquisition of discrete skills, such as interpreting specific assessment measures, or development of more fluid abilities such as improving assertiveness with patients or balancing fidelity to evidence-based treatments with accommodating patient needs. These goals are not evaluated formally; however, progress is discussed frequently during supervision.

The supervisors make every effort to honor the preferences of the fellow; however, they reserve the right to require certain training experiences if a significant need is identified. The training plan may be revisited and amended at any point in the training year as new interests or needs are identified. At midyear and end-of-year all fellows will formally review their training plans and progress with the Training Director and/or Associate Training Director and primary supervisor.

CLINICAL ROTATIONS

General Outpatient (Major Rotation completed by all fellows): All fellows will complete this rotation. This rotation takes place in the Outpatient Mental Health Clinic and may also include at least

one day per week in the Emergency Room Direct Access clinic. Fellows will perform assessments and provide therapy to active-duty patients presenting with a variety of issues. The rotation emphasizes developing the fellow's ability to make clinical decisions regarding military fitness; for example, fitness or suitability for continued service, ability to deploy, or ability to handle weapons. The fellow will gain familiarity and comfort in communicating with patients' commands and with other medical providers. The fellow will also military-specific procedures and associated documentation, such as medical boards and administrative separations. As noted above, assuming supervisor availability and agreement of primary supervisor, fellows may elect during this rotation to see some cases outside of their specialty track, such as child or health cases.

Mood Disorders and PTSD (Major Rotation completed by fellows on the Mood Disorders and PTSD track): The fellow will conduct diagnostic interviews and provide treatment to patients with PTSD and depression and, for the sake of breadth of training, will also see some patients with other anxiety and mood disorders. The fellow will conduct initial diagnostic interviews to establish diagnoses and to determine symptom severity, suicide/homicide risk factors, and substance use issues. The fellow will also develop appropriate treatment plans and provide evidence-based treatments in accordance with the DOD/VA Clinical Practice Guidelines. First-line treatment approaches would include Prolonged Exposure Therapy and Cognitive Processing Therapy for patients suffering from PTSD and Cognitive Behavioral Therapy and Acceptance and Commitment Therapy to patients suffering from depression. Additionally, fellows will utilize other treatment techniques, such as Dialectical Behavior Therapy and group therapy, as appropriate.

Child and Family Intervention (Major Rotation completed by fellows on the Child and Family Intervention track): The rotation emphasizes responding to the unique challenges military families face while utilizing evidence-based therapeutic interventions for various treatment needs. This rotation takes place in the Child Mental Health Clinic. The rotation prepares the fellow to provide assessment, intervention and consultation with families of active-duty service members. Fellows will develop skills in the areas of diagnostic interviewing, treatment planning, and providing appropriate interventions and case management. Fellows will provide individual, group, and family therapy and consult with medical providers, school personnel, and commands, as necessary. Fellows will also develop competence in conducting comprehensive psychological evaluation/assessment for the purposes of diagnostic clarification and treatment planning. Fellows will receive exposure to Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for disruptive behavior and attachment problems in preschool-age children. Groups provided in this clinic include psychoeducation and skill building to address anger management, AD/HD, anxiety, parenting, mood, and self-harm. Other opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate. The fellow will primarily be supervised by a child psychologist but will also have the opportunity to work with psychiatrists (attending and residents) and licensed clinical social work staff.

Health Psychology (Major Rotation completed by fellows on the Health Psychology Track): The health psychology major rotation takes place in the Adult Outpatient Mental Health Clinic and other services throughout the hospital. 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 fellow will gain exposure to instruments used to assess emotional and behavioral components of chronic pain. The fellow will have the opportunity to consult with physical therapists, physiatrists, surgeons, and anesthesiologists. Fellows also work with an outpatient intensive TBI program to provide mindfulness-based weekly groups.

Further, fellows will provide group Brief Behavioral Treatment for Insomnia, as well as other possible health psychology group interventions. Fellows are encouraged to develop partnerships with other medical clinics in the hospital that are in line with their clinical interests (e.g., diabetes management, infertility, or oncology).

Acute/Inpatient Care (Minor Rotation completed by all fellows): All fellows will complete this rotation. As part of this learning experience, fellows work under the supervision of their primary supervisors in addition to receiving supervision from attending inpatient psychiatrists and other providers involved in acute care. This training experience is sequenced at the beginning of the training year and takes place in inpatient psychiatric units and the NMCP Emergency Room The psychiatric units provide intensive inpatient psychiatric treatment for patients with primary psychiatric disorders and dually diagnosed patients (i.e., patients diagnosed with a substance use disorder and co-occurring psychiatric disorder) and service both active duty and adult family members. The fellow will attend and participate in morning rounds, interview new patients, develop and monitor treatment/discharge plans, provide individual therapy/crisis intervention, co-facilitate process groups on the ward with psychiatry trainees, and conduct psychological testing as needed. The fellow will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated mental health services. The fellow will also consult with family members and the commands of active duty service members to make decisions regarding military disposition. In the NMCP Emergency Room, fellows work as a team with residents to evaluate patients for possible hospitalization. They communicate with patient family members and commands to gain collateral information, provide feedback, and create safety plans. Fellows may also spend time during this rotation providing consult/liaison services to patients on medical wards in the hospital who have co-morbid psychiatric issues. During this month-long rotation, fellows will spend approximately one day per week in the Adult Mental Health Clinic seeing 1-2 individual therapy patients.

Embedded Psychology (Minor Rotation completed by all fellows): All fellows will complete this rotation. The fellow will spend one day per week for at least 10 weeks working under the supervision of a psychologist in an embedded setting: on one of the US Navy aircraft carriers docked at either Naval Station Norfolk or the Norfolk Naval Shipyards; with the local submarine squadrons; or another embedded setting that becomes available. Fellows will have the opportunity to evaluate and treat patients in an embedded setting, to do treatment planning with other medical providers such as the Ship's Medical Officer or the Undersea Medical Officer, and to interface with command leadership. Fellows will gain invaluable experience at making decisions about military-specific factors such as a patient's ability to deploy or maintain submarine or nuclear qualifications. Placement at a specific embedded site is dependent on availability of a supervising psychologist in an embedded setting, on fellow interests, and on the fellow's planned post-fellowship placement (for example, a fellow who is scheduled to go on an aircraft carrier after fellowship would have first priority at an embedded carrier experience).

Substance/Alcohol Addiction (Mini-Rotation): All fellows will complete this mini-rotation. For this brief introductory mini-rotation the fellow will spend 5 days during the training year within the Substance Addiction Rehabilitation Program (SARP) located at Naval Medical Center Portsmouth. Supervision is provided by a licensed psychologist assigned to SARP. SARP is a 72-bed co-occurring substance addiction treatment facility that provides a full range of treatment services to active-duty military personnel, their family members, and retirees. The fellow will be oriented to the field of substance addiction treatment and will develop skills necessary to assess for substance addiction,

program placement and provide substance addiction treatment to adult clients. Initially, all fellows participate in a set of core didactic trainings offered at SARP and subsequently participate in a broad range of professional services including substance addiction assessment, treatment planning, individual therapy, and group therapy. Fellows are also exposed to the nonclinical administrative roles assumed by psychologists within this treatment environment. Specifically, they gain experience in the areas of addictions counselor training, and participate in peer review, process improvement, and business plan meetings. The fellows are not evaluated formally at this mini-rotation and therefore do not complete supervision contracts. However, the training team does receive informal feedback from SARP staff.

SUPERVISION

Fellows will receive a minimum of four hours of supervision each week. At least two of these hours will be individual supervision provided by the major/primary and minor rotation supervisors who have assumed clinical responsibility for the patients seen by the fellow. The remaining two hours will be provided in a group supervision format that is attended by training faculty, fellows and interns and affords the opportunity for supervised peer supervision and interaction. Additional supervision may also be provided by a licensed practitioner in a related discipline, e.g., a psychiatrist or clinical social worker. Fellows can also expect significant amounts of unscheduled supervision between scheduled supervision appointments. Fellows submit **Weekly Clinical Supervision Forms** (Appendix I) each week documenting supervision hours. These forms also document various aspects of the week's supervision, such as whether or not audio/video recordings of clinical work were reviewed, supervisor's direct feedback to fellows, and issues in the supervisor-supervisee relationship. Additionally, fellows are required to delineate which of advanced competencies and program specific competencies that form the basis of our competency determinations were addressed during the week. This information is entered into a data base by the Training Administrative Assistant and may be accessed by fellows if need arises and by supervisors and the Training Director for program evaluation and process improvement purposes. 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 the Training Director and the fellow's primary supervisor are promptly informed. The primary supervisor then establishes a plan for making-up the missed hours and the Administrative Assistant collects documentation attesting to the success of this plan.

EMBEDDED EXPERIENCES

In addition to their Embedded minor rotation, fellows will receive further embedded experiences during the training year. Particular emphasis will be placed on gaining familiarity with the stresses unique to the Navy and Marine Corps operational commands, and on developing skills for effective consultation with these commands. Fellows will have the opportunity to participate in embedded experiences as they become available during the training year. Examples of embedded experiences include but are not limited to the following: underway aboard an aircraft carrier, direct Fleet consultation and intervention on Special Psychiatric Response Intervention Team missions; train with and train with and observe advance assessment and selection with Marine Corps Embassy Security Group; train with and observe Navy psychologists attached to United States Marine Corps air commands, ground commands logistics commands; or train with and observe psychologists assigned to Operational Stress Control and

Readiness (OSCAR) Teams. It is important to note that the Navy and Marine Corps operational and training environment is very dynamic. We frequently adjust our embedded training activities to meet changing organizational and training demands and opportunities. Therefore, embedded experiences will be based on fellow's interest, the timing of available opportunities within the various embedded environments, and developmental needs of the fellow.

EXTRA-CURRICULAR MILITARY DUTIES

All trainees are active-duty Navy officers. As such, they may be assigned military-specific duties by the leadership of the Psychology Division. Such duties are outside of the training curriculum and are assigned in consultation with the Training Director and clinical supervisors. Examples of assigned military duties include representing the department at military functions, preparing short-fused informational briefs for leadership, and participating in Human Resource Department investigations. It is the duty of each trainee to ensure that patient safety and welfare are always maintained, even in the presence of conflicting military duties. Accordingly, trainees must promptly inform clinical supervisors of circumstances that will result in a disruption in clinical activities and/or an inability to participate in planned program elements (e.g., scheduled supervision, didactic presentations). Missed training activities generally cannot be made up. The frequency and duration of military assignments are not expected to significantly interfere with the trainee's ability to successfully complete the training program or meet the minimum number of training days required for graduation.

PREPARING FELLOWS TO SERVE A DIVERSE MILITARY

A goal of our training program is to foster the ability of our fellows to provide competent care to service members and their families (and to the general public once the intern leaves active-duty service) , and fellows' competencies in professional practice are evaluated regularly. Some fellows may possess worldviews, values or religious beliefs that conflict with serving specific subgroups within the public. For example, they may experience strong negative reactions toward clients/patients who are of a particular sexual orientation, religious tradition, political affiliation, age or disability status. Supervisors take a developmental approach to trainee skill and competency acquisition and support individual fellows in the process of developing competencies to work with diverse populations. Supervisors respect the right of fellows to maintain their personal belief systems while acquiring such professional competencies. Supervisors also model the process of personal introspection; the exploration of personal beliefs, attitudes and values; and the development of cognitive flexibility required to serve a wide range of clients/patients. Training to work with diverse clients/patients is integral to the curriculum and consists of both didactic coursework and practical training.

Training programs, supervisors and fellows cannot be selective about the core competencies needed for the practice of psychology because these competencies are determined by the profession for the benefit of the public. Further, training programs are accountable for ensuring that fellows exhibit the ability to work effectively with clients/patients whose group membership, demographic characteristics or worldviews create conflict with their own. Supervisors respectfully work with fellows to beneficially navigate value- or belief- related tensions. At times, we will consider patient re-assignment, so fellows have time to work to develop their competence to work with patients who challenge fellows' sincerely held beliefs. Supervisors utilize professional judgment in determining when patient re-assignment may be indicated in this situation as in all other possible situations in which patient re-assignment may be

considered. The overriding consideration in such cases will always be the welfare of the patient. In such cases, supervisors focus on the fellows' development, recognizing that tensions arising from sincerely held beliefs or values require pedagogical support and time to understand and integrate with standards for professional conduct. Thus fellows entering our training programs should have no reasonable expectation of being exempted from having any particular category of potential clients/patients assigned to them for the duration of training.

ADVERSE ACTION AND DUE PROCESS

Introduction: It is the goal of the program to educate and graduate clinical psychology postdoctoral fellows. The faculty recognizes its duty to provide special assistance to fellows who are having difficulty learning. When fellow is determined to be making insufficient progress, faculty supervisors and the fellow involved will cooperatively attempt to find the reasons for the difficulties in order to develop a thoughtful and comprehensive plan for remediation. It is the program's express intent to separate disciplinary matters from failure to learn and progress.

The program adheres to the Naval Medical Center Portsmouth Graduate Medical and Dental Education Adverse Action and Due Process Graduate Medical Education Committee: Graduate Medical and Dental Education Adverse Action and Due Process Policy (Appendix L: 15 MAR 2024). Serious disciplinary infractions will be handled through the NMCP chain of command (e.g. the Director for DMH, and the NMRTC-P Commander), and may result in formal counseling statements, letters of reprimand, or even non-judicial punishment under the Uniform Code of Military Justice. It is recognized that not all transgressions or ethical violations should be viewed simply as disciplinary matters. Some may be due to ignorance or misunderstanding and therefore legitimately require concurrent remedial training under this training manual.

Fellows may be extended, placed on probation, or terminated for any of the following reasons:

- Individual request for voluntary withdrawal.
- Unacceptable moral or ethical conduct.
- Violation of Service-related disciplinary or administrative standards.
- Prolonged absence, to include medical leave from the program.
- National Emergencies (not a cause for termination).
- Medical/Family/Personal leave of absence that may extend training.
- Less than satisfactory academic or professional performance.

In order to receive a certificate of completion, all training elements must be satisfactorily completed (i.e., performance must meet or exceed minimally acceptable levels). If deficient performance is noted by a supervisor during a clinical rotation, the supervisor is responsible for immediately communicating specific examples of the problem(s) and suggestions for improvement to the fellow and documenting such on weekly supervision forms. The faculty recognizes its duty to provide special assistance to fellows who are having difficulty meeting expected competencies of the program. When a fellow is determined to be making insufficient progress, faculty supervisors and the fellow involved will cooperatively attempt to find the reasons for the difficulties in order to develop a thoughtful and comprehensive plan for remediation. Performance concerns are also shared by the supervisor with the

Training Director and members of the fellow's Competency Committee and other training faculty during regularly scheduled Training Committee meetings. This first step is an informal process and does not result in placement of the fellow into a remedial or probationary status.

Fellows remain in good academic standing within the training program unless they

1) perform at an unsatisfactory level in a major or minor rotation, as rated by the rotation supervisor at the end of the training experience;

2.) obtain a minimally satisfactory supervisor rating in a major rotation or two minimally satisfactory ratings in minor rotations; and/or

3.) obtain competency ratings at the mid-year or end of year evaluations that fall below the minimally acceptable levels, as outlined above.

In one of the above criteria is met, the fellow can be placed on Departmental Remediation and a specific, written, remediation plan is developed by his/her Competency Committee. This plan clearly outlines the essential features of each deficient competency domain or subpar aspect of rotation performance and specifies the nature of the assistance that will be provided by the training faculty geared toward the remedial effort, a time frame for completing the remediation process, and the methods by which the trainee will be evaluated. The fellow and members of the Competency Committee sign this plan. This is considered department mental remediation, so while the Graduate Medical and Dental Education Committee (GMEDC) is notified of this event, the GMEDC does not take any actions. Successful completion of the remediation plan returns the fellow to good standing in the program. Failure to remediate performance deficiencies may lead to a second period of departmental remediation or, at the discretion of the Training Committee, a referral is made to the GMEDC and the **GMEDC Adverse Pathway** (Appendix M) is followed. In the event that the GMEDC determines that command probation, suspension, remediation, or probation is warranted, the fellow's competency committee develops a second, written remedial plan which, again, outlines specific deficiencies, offers a timeframe and plan for remediating them, and delineates the manner in which performance will be evaluated.

Failure to successfully meet competencies during one of the above periods is likely to result in a request from the Psychology Training Committee to the GMEDC for termination from the fellowship. It is also possible that a fellow will require an extension of the training year to complete the program if placed on either remediation, probation, or suspension, especially if the performance deficiency is revealed at or near the end of the training year. Training year extensions must be submitted for recommendation to the GMEDC and approved by the Commanding Officer. The fellow's rights to due process protections are maintained throughout all actions initiated for deficient performance. Fellows are entitled to representation by a Navy legal officer (attorney), free of charge.

A fellow may be terminated 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 GMEDC and involve the military chain of command with input from the Judge Advocate's (i.e. Legal Department) office. As is the case for all Navy Service members, poor performance or unacceptable personal behavior will be reflected in the fellow's periodic military fitness report.

GMEDC APPEAL PROCESSES

Any intern who has received formal written notification from the Chairperson of the GMEDC of a recommendation for delay in completion, termination or training, or has had patient care activities suspended may request a review of the action by the GMEDC. The intern will have 10 business days from the date of the recommendations are delivered to submit a written request seeking review. All hearing rights are reviewed in the GMEDC. See Appendix EE for a full review of the appeals/right to hearing policy.

EQUAL OPPORTUNITY POLICY

Instructions for the **Command Equal Opportunity Program** can be found in the link located in Appendix FF. Further guidance is available at are available online at the Navy Bureau of Personnel website (http://www.public.navy.mil/bupers-npc). A hard copy can also be obtained via NMCP Equal Opportunity Employment Office. Fellows electing to make a formal complaint of sexual harassment or assault may contact the chain of command, or the DoD Sexual Assault Support Hotline at 877-995-5247. Further guidance is available at https://www.sapr.mil/public/docs/news/DoD_Safe_Helpline_SARC_Guidance.pdf

The Clinical Psychology fellowship operates in accordance with Naval Medical Center, Portsmouth's Equal Opportunity Policy. In a positive and effective work environment, all persons are treated with respect, dignity, and basic courtesy. Equal opportunity and treatment will be provided for all personnel. The program 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.

GRIEVANCE PROCESS

NMCP supports both an informal and formal grievance policy. Fellows wishing to make a complaint or grievance against the Psychology Training Program, a specific supervisor, or any other NMCP staff member for any perceived unethical behavior, discrimination or harassment should follow the guidance of NAVMEDCENPTSVA INSTRUCTION 5354.2. The first consideration should be toward the informal mechanisms for resolution, In accordance with conflict resolution research, the APA ethical code, and general principles of human resource management. See **Informal Grievance Decision Matrix** (Appendix GG). NMCP's grievance policy is that the fellow should first attempt to resolve any complaint at the lowest level possible. Even if the fellow can resolve the situation without assistance from a supervisor, the fellow should inform his/her immediate supervisor of the situation and resolution. Informing the supervisor is necessary in case there is a history/pattern of inappropriate behavior of which the fellow may not be aware of, or in case something happens in the future that may indicate a pattern or trend.

For example, if there is a problem or concern with a specific supervisor, the fellow 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 fellow 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 fellow 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 fellow 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. If an fellow has a complaint with the Training Director, the Psychology Chair will follow the above guidelines in resolving the issue.

The procedures hereafter are more formal ones and extend beyond the program and DMH. If informal channels fail to bring a resolution that is satisfactory to the fellow, the next step in the process would be for the fellow to make a formal grievance as outlined in the **Formal Grievance Decision Matrix** (Appendix HH).

The complaint will be reviewed by the NMRTC Commander who will determine the level of the investigation. An Investigating Officer will be assigned in writing by the Commander. The Commander will review the results of the investigation and make a determination. If the individual filing the grievance is not satisfied with the Commander's decision, he/she may appeal the Commander's decision. The case will be forwarded to the next level of the Chain of Command. If the issue is still not resolved the next and final step is a review and determination by the Secretary of the Navy (SECNAV). The findings of the SECNAV are final.

In addition to the above, at any point in the training year fellows may request a review of any program policy by the 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. Fellows are informed of the time and place of this meeting. After stating their request to the committee, the fellow is excused from the room while committee members debate the issue. The fellow is recalled to the meeting when a decision has been reached. If the issue is not resolved to the fellow's satisfaction, the grievance policy may be applied.

PROGRAM EVALUATION BY FELLOWS

Fellows provide feedback regarding the adequacy of their training experiences at various points during the training year. At the completion of each training rotation the fellow completes a **Supervisor Evaluation Form** (Appendix R) which is reviewed with the supervisor and then submitted to the Training Director. Additionally, at the mid-point of the training year fellows complete a **Mid-Year Evaluation of the Program Form** (Appendix S) that addresses level of satisfaction with their training experiences to date and allows for offers of recommendations for program improvement. Lastly, at the end of the training year fellows complete an **End-of-Year Evaluation of Program Form** (Appendix T). The fellows' evaluations of supervisors and of the program include an assessment of the degree to which the 3 advanced and 4 focused, program specific competency domains were addressed. Fellows also complete anonymous Learning Climate Surveys (Appendix V and Appendix W) on a quarterly basis. Following graduation, fellows are surveyed yearly for 7 years using the **Program Outcomes and Monitoring Questionnaire** (Appendix U) to determine the relevancy of the training program to their current and anticipated future professional functioning.

POLICY ON ABSENCES

Fellows are required to plan their absences, well in advance and to submit their requests in a manner that will allow adequate review by the rotation supervisor and Training Director. With rare exceptions under special circumstances, no more than five working days personal leave will be permitted during the training year. All requests for absences are contingent upon the projected requirements of the fellow's training assignments and upon the fellow's progress in the training program. Above all, patient care responsibilities are primary. If a fellow is unable to come to work due to illness or injury, he/she should notify the Training Director, his/her supervisors, and the administrative staff should be notified if patients need to be rescheduled for that day. If a fellow is to miss more than two consecutive days due to illness or injury then he/she should present to sick-call, or if appropriate the Emergency Department for as medical determination as to when he/she will be able to resume training duties. If a fellow needs to be absent due to a family or personal emergency, the Training Director should be notified immediately.

A. Fellows may be absent for five days over the course of the training year for personal leave.

B. All requests for absences are contingent upon the projected requirements of the fellow's training assignments and upon the fellow's progress in the fellowship. Above all, patient care responsibilities are primary.

C. If more than a total of 15 days are expended on personal, emergency, or medical leave, it may be necessary to extend the training year. Fellows 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.

D. Time away for meeting academic requirements, such as completing Examination for Professional Practice in Psychology, is available and supported. Please work with rotation supervisors and the Training Director on scheduling well in advance, to avoid needing to cancel patients who are already scheduled.

E. Leave requests are submitted electronically to the Training Director through the Navy Standard Integrated Personnel System (NSIPS).

APPLICANT QUALIFICATIONS, APPLICATION PROCESS AND BENEFITS

Application to the Naval Medical Center Portsmouth Clinical Psychology Fellowship Program is processed through the Navy Recruiting Command (for Navy Officer commissioning clearance). The officer commissioning part of the application process is NOT made directly to the fellowship program. As applicants to the fellowship are also applying to become active duty naval officers, they must meet all age, security background check, and medical requirements for commissioning as naval officers. Applicants do not need to be in the military to apply, and despite the extensive officer commissioning background process during the application, there is no subsequent military service obligation unless an applicant is offered a position in the fellowship

Military specific requirements include: Applicants must be US Citizenship (dual citizens must agree to relinquish non-US citizenship if selected for the fellowship). No more than 41 years of age at the time of commissioning (typically in June or July of the year in which the fellowship starts).

Individuals interested in applying for our postdoctoral fellowship training program must submit a resume/CV, graduate school transcript, three letters of recommendation, and documentation certifying completion of a Ph.D. or Psy.D. in Clinical or Counseling Psychology from an APA-accredited doctoral program, and documentation certifying completion of an APA-accredited pre-doctoral internship (non APA accredited programs will be considered on a case by case basis).

Applicants will have completed all requirements for the psychology doctoral degree (including dissertation and doctoral internship) before attending Officer Development School (ODS typically runs between August – September) and starting the Fellowship (in September or October). The doctoral program must be APA-accredited. APA-accredited doctoral internship preferred. Waivers may be granted on a case-by-case basis for applicants whose doctoral internship was not APA-accredited. The fellowship program gives careful consideration to all available information about each applicant and selects fellows on a competitive basis without regard to race, sex, sexual orientation, religion, creed, color, or national origin (Article 1164 Navy Regulations: https://doni.daps.dla.mil/US%20Navy%20Regulations/Chapter%2011%20-%20General%20Regulations.pdf). Competitive applicants should have most of their clinical experience with a clinically broad range of adult patients. Training and experience in evidenced based treatments consistent with DOD/VA guidelines for traumatic stress related disorders and/or depression spectrum disorders are preferred. Neuropsychology, health psychology, and child psychology experience is welcome, but should not have been the sole focus of graduate school training.

For individuals currently enrolled in a pre-doctoral internship, letters in support of the applicant must be received from training directors of both the doctoral program and the internship program. The letter from the doctoral program training director must state that all requirements for the doctorate will be met upon successful completion of the internship. This statement may be included in a letter of recommendation from the doctoral program training director and thereby qualify as one of the three required letters of recommendation. Additionally, the letter from the internship training director must state that the individual is in good standing in the internship and is expected to graduate from the

internship on time. This statement may be included in a letter of recommendation from the internship training director and additionally qualify as one of the three required letters of recommendation. Individuals who have completed, or are currently enrolled in, an internship that is not yet APA accredited but that is in the process of applying for accreditation will be considered on a case by case basis.

Prospective applicants should contact the Navy Recruiting Office in their local areas. This office can typically be found in the Government Pages of the local telephone directory. Applicants should specifically ask for the person in charge of Medical Officer Recruiting. Often, small recruiting offices will not have Medical Officer Recruiters but can easily direct the applicant to the closest Medical Officer Recruiter. As part of the application process, interview appraisal from two Navy psychologists (active duty or civilian) must be submitted. Interviews will be offered at NMCP at an announced date (typically the last week in November). Applicants are encouraged to attend this in person interview opportunity. In the event that an applicant is unable to travel, Navy Recruiters will arrange for these interviews. At least one of the interviews should be face-to-face, while the other may be via phone.

Prior to beginning the Postdoctoral Fellowship, prospective fellows are commissioned as Lieutenants (0-3) in the Navy Medical Service Corps and required to attend and successively complete a five-week training program through the Officer Development School (ODS) at Newport, Rhode Island. Upon completion of ODS, fellows will typically attend Navy Medicine 101 in Bethesda, MD and then move along to assignment to serve and train at Naval Medical Center Portsmouth, Virginia. Fellows have a 3-year military service obligation following completion of the one-year fellowship. Continued service as a Navy psychologist beyond this initial 4-year commitment is an option. At the end of the fellowship year, fellows 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, overseas service, and deployment with operational forces. Unlicensed fellows are expected to complete licensure requirements in the state of their choice within 18 months of enrollment in this program. Annual compensation can be roughly estimated at https://militarypay.defense.gov/calculators/rmc-calculator/ . Persons with family members and/or prior military service may receive more financial compensation than those without dependents. Health care expenses are fully covered for all fellows and eligible 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 a number of legal services.

Other Requirements: Applicants must meet medical and security qualifications for commissioning as a U.S. Navy Medical Service Corps officer. This part of the application is completed with the assistance of a Navy Medical Programs Officer Recruiter.

QUALITY ASSURANCE

In order to assure the maintenance of the standards of quality patient care, the following steps will be taken by the faculty. The Program Director is responsible for assuring that each step is accomplished.

1. Supervisors will submit written rotation competency evaluations to the fellow and the Program Director indicating that the evaluation of the fellow has taken place as scheduled.

2. At the mid-point and end of the fellowship year, each fellow will submit to the Program Director a formal evaluation of the training received (see section: PROGRAM EVALUATION BY FELLOWS, page #27 of this manual for relevant procedures).

FOR ADDITIONAL INFORMATION

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

Michael Franks, Psy.D., MP, ABPP
CAPT, Scientist, PHS, USN
Training Director
Mental Health Department, Psychology Training Programs Naval Medical Center
620 John Paul Jones Circle
Portsmouth, VA 23708-2197
(757) 953-5269
Michael.j.franks2.mil@mail.mil

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

John A. Ralph, Ph.D., ABPP
CAPT, MSC, USN (ret)
National Director
Navy Psychology Training Programs

Walter Reed National Military Medical Center
Bethesda, MD 20889
(301) 295-2476
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APPENDIX A

Competency Benchmarks for Clinical Psychology Postdoctoral Fellowship

Naval Medical Center Portsmouth

Competency Benchmarks for Clinical Psychology Postdoctoral Fellowship

This document is based on 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.* They describe competency domains for professional psychologists and offer criteria, or benchmarks, for assessing three levels of professional development; i.e., Readiness for Practicum, Readiness for Internship, and Readiness for Entry to Practice. We have modified Fouad and colleagues benchmarks to fit the expected competencies of our training model, which are consistent with the APA Commission on Accreditation *Standards of Accreditation in Health Service Psychology,* and expanded the benchmarks to include Readiness for Fully Autonomous Practice and Readiness for Lifelong Learning/Master Clinician, criteria for which were derived by our professional staff as logical extensions of the prior work. Our assessed competencies include the advanced competencies of integration of science and practice as it pertains to scientific knowledge and methods, assessment, intervention, research/evaluation, supervision, and teaching; biopsychosocial; and ethical legal standards and practice. In addition, we use the benchmarks to assess our program specific competencies of consultation and advocacy as they pertain to interdisciplinary systems, consultation, relationships and advocacy; management and administration, professionalism; and reflective practice/self-assessment/self-care. Our benchmarks are intended to be used with a collection of instruments, our "toolkit", which runs parallel to recommendations made in an article that accompanied the Fouad et. al. publication, *Competency Assessment Toolkit for Professional Psychology* (Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfa, 2009). Furthermore, we incorporate a Competency Rating Scale, which allows us to assess competency development using a numerical scale that breaks down each competency level into finer gradations.

Competency Rating Scale

1.00 Meets criteria for Readiness for Practicum

1.25 Slightly 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 Slightly 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 Slightly 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 Slightly 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

Advanced Competencies

I. Integration of Science and Practice

A. 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.

1.0 Readiness for Practicum

Essential Components	A) Scientific Mindedness: Critical scientific thinking	B) Scientific Foundations of Psychology: Understanding of psychology as a science	C) Scientific Foundation of Professional Practice: Understanding the scientific foundation of professional practice
Behavioral Anchor	Aware of the need for evidence to support assertions; Questions assumptions of knowledge; Evaluates study methodology and scientific basis of findings; Presents own work for the scrutiny of others	Demonstrates understanding of core scientific conceptualizations of human behavior;	Understands the development of evidence-based practice in psychology (EBP) as defined by APA; Displays understanding of the scientific foundations of the functional competencies; Cites scientific literature to support an argument; Evaluate scholarly literature on a practice-related topic

Scientific Knowledge and Methods

2.0 Readiness for Internship

Essential Components	A) Scientific Mindedness: Values and applies scientific methods to professional practice	B) Scientific Foundation of Psychology: Knowledge of core science	C) Scientific Foundation of Professional Practice: Knowledge, understanding and application of the concept of evidence-based 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	Displays intermediate level knowledge of and respect for scientific basis of behavior Demonstrates understanding of psychology as a science, including basic knowledge of the breadth of scientific psychology. For example: able to cite scientific literature to support an argument; Evaluates scholarly literature on a topic	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.

Scientific Knowledge and Methods

3.0 Readiness for Entry to Practice

Essential Components	A) Scientific Mindedness: Independently applies scientific methods to practice	B) Scientific Foundations of Psychology: Knowledge of core science	C) Scientific Foundations of Professional Practice: Knowledge and understanding of scientific foundations independently applied to practice
Behavioral Anchor	Independently accesses and applies scientific knowledge and skills appropriately and habitually to the solution of problems;	Demonstrates advanced level of knowledge of and respect for scientific knowledge of the bases for behavior	Reviews scholarly literature related to clinical work and applies knowledge to case conceptualization; Applies EBP concepts in practice; Compares

	Readily presents own work for the scrutiny of others		and contrasts EBP approaches with other theoretical perspectives and interventions in the context of case conceptualization and treatment planning

Scientific Knowledge and Methods

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Scientific Mindedness:** Independently and consistently applies scientific methods to practice	**B) Knowledge:** Articulates advanced knowledge of core science	**C) Scientific Foundations:** Knows and understands scientific foundations and consistently and independently applies this knowledge to practice in a flexible manner
Behavioral Anchor	Exhibits ability to independently and consistently access and apply scientific knowledge & skills appropriately and habitually to the solution of problems; Encourages others to scrutinize work samples	Demonstrates advanced knowledge of and respect for scientific knowledge of the bases for behavior, and consistently incorporates this into professional practice	Critically reviews scholarly literature related to clinical work and applies knowledge to case conceptualization; Demonstrates ability to modify in a systematic and scientifically defensible manner the application of EBP concepts in clinical cases for which standard EBP procedures are not appropriate or prove to be ineffective

Scientific Knowledge and Methods

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	A) Scientific Mindedness: Routinely applies scientific methods to practice in both traditional and novel ways	B) Knowledge: Advanced knowledge of core science and highly developed ability to make useful application of knowledge.	C) Scientific Foundations: Engages in activities that advance basic methodological approaches to the study of human behavior
Behavioral	Consistent pattern of the	Demonstrates advanced	Proposes, via the professional literature and

Anchor	application of scientific methods in clinical practice; demonstrate novel applications of science to clinical practice; elicits scrutiny of work samples from advanced practitioners	knowledge of and respect for the scientific bases of behavior by extensive reading of, and discussion about, the psychological literature and the literatures of other germane disciplines; consistently incorporates advanced knowledge of human behavior into professional practice	other public venues, new methodologies that lead to paradigm shifts in the profession's approach to understanding human behavior

B. Assessment

Assessment and diagnosis of problems capabilities and issues associated with individuals, groups, and/or organizations.

1.0 Readiness for Practicum

Essential Components	**A) Measurement and Psychometrics:**	**B) Evaluation Methods:**	**C) Application of Methods:**	**D) Diagnosis:**	**E) Conceptualization and Recommendations:**	**F) Communication of Findings:**
	Basic knowledge of scientific, theoretical, and contextual basis of test construction and interviewing	Basic knowledge of administration and scoring of traditional assessment measures, models and techniques, including clinical interviewing and mental status exam	Knowledge of measurement across domains of functioning and practice settings	Basic knowledge regarding the range of normal and abnormal behavior in the context of stages of human development and diversity	Basic knowledge of formulating diagnosis and case conceptualization	Awareness of models of report writing and progress notes

Behavioral Anchor	Demonstrates awareness of the benefits of standardized assessment; Demonstrates knowledge of the construct(s) being assessed; Evidences understanding of basic psychometric constructs such as validity, reliability, and test construction	Accurately and consistently administers and scores various assessment tools in non-clinical (e.g., courses) contexts; Demonstrates knowledge of initial interviewing (both structured and semi-structured, mini-mental status examination	Demonstrates awareness of need to base diagnosis and assessment on multiple sources of information; Demonstrates awareness of need for selection of assessment measures appropriate to population/ problem	Identifies DSM-V criteria; Describes normal development consistent with broad area of training	Demonstrates the ability to discuss diagnostic formulation and case conceptualization; Prepares basic reports with articulate theoretical material	Demonstrates this knowledge including content and organization of test reports, mental status examination, interviews

Assessment

2.0 Readiness for Internship

Essential Components	**A) Measurement and Psychometrics:** Selects assessment measures with attention to issues of reliability and validity	**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	**C)Application of Methods:** Selects appropriate assessment measure to answer diagnostic question	**D) Diagnosis:** Applies concepts of normal/abnormal behavior to case formulation and diagnosis in the context of stages of human development and diversity	**E) Conceptualization and Recommendations:** Utilizes systematic approach of gathering data to inform clinical decision-making	**F) Communication of Findings:** Writes assessment reports and progress notes
Behavioral Anchor	Identifies appropriate assessment measures for cases seen it practiced site; Routinely consults with supervisor regarding selection of assessment measures	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 mini-mental status exams	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	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	Presents cases and reports demonstrating how diagnosis is based on case material	Writes a basic psychological report; Demonstrates ability to communicate basic findings verbally; Reports reflect data that has been collected via interview

			client needs (e.g., Lighting, privacy, ambient noise)			

Assessment

3.0 Readiness for Entry to Practice

Essential Components	**A) Measurement and Psychometrics:** 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	**B) Evaluation Methods:** Independently understands the strengths and limitations of diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning	**C) Application of Methods:** 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	**D) Diagnosis:** Utilizes case formulation and diagnosis for intervention planning in the context of stages of human development and diversity	**E) Conceptualization and Recommendations:** Independently and accurately conceptualizes the multiple dimensions of the case based on the results of assessment	**F) Communication of Findings:** Communicates results in written and verbal form clearly, constructively, and accurately in a manner appropriate to context.
Behavioral Anchor	Demonstrates awareness and competent use of culturally sensitive instruments, norms; Seeks	Accurately and consistently selects, administers, and scores and interprets assessment tools with clinical populations;	Independently selects assessment tools that reflect awareness of client populations served at practiced site;	Treatment plans incorporate relevant developmental features and clinical symptoms as applied to	Independently prepares reports based on assessment data; Administers, scores and interprets test results; Formulates case	Writes an effective comprehensive report; Effectively communicates results verbally in a manner appropriate to the listener and context

	consultation as needed to guide assessment; Demonstrates awareness of limitations of various forms of assessment data	Selection of assessment tools reflects a flexible approach to answering the diagnostic questions; Includes in reports a 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	Interprets assessment results accurately taking into account limitations of the evaluation methods; Provides meaningful, understandable and useful feedback that is responsive to client need	presenting problems; Demonstrates awareness of DSM-V and relation to ICD-10 codes; Regularly and independently identifies problem areas and makes a diagnosis	conceptualizations incorporating theory and case material	

Assessment

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Measurement and Psychometrics:** Able to verbalize a technical rationale for selecting and implementing differing methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context	**B) Evaluation Methods:** Advanced knowledge of administration and scoring of traditional assessment measures, models and techniques, including clinical interviewing and mental status exam	**C) Application of Methods:** Independently and skillfully administers a variety of assessment tools and integrates results to accurately evaluate presenting question appropriate to the practice site and broad area of practice	**D) Diagnosis:** Utilizes case formulation and diagnosis in complex cases for intervention planning in the context of stages of human development and diversity	**E) Conceptualization and Recommendations:** Independently and accurately conceptualizes the multiple dimensions of complex cases based on the results of assessment	**F) Communication of Findings:** Demonstrates ability to communicate results in written and verbal form with a high degree of both clarity and accuracy, in a conceptually appropriate manner for complex case presentations
Behavioral Anchor	Demonstrates keen understanding of the benefits of standardized assessment; Demonstrates advanced knowledge of the construct(s) being assessed; Demonstrates advanced understanding of basic	Habitually and accurately administers and scores various assessment tools in the clinical setting; Demonstrates advanced knowledge of initial interviewing (both structured and semi-structured, mini-	Demonstrates knowledge of and ability to base diagnosis and assessment on multiple sources of information; Demonstrates ability to determine appropriate selection of assessment measures to	Treatment plans integrate relevant developmental features and clinical symptoms as applied to presenting problems among clients with complex presentations; Demonstrates	Independently prepares reports based on assessment data for clients presenting with complex features/symptoms; Administers, scores and interprets test results in a highly accurate manner; Formulates case conceptualizations	Writes an effective, comprehensive report that strikes a balance between efficiency (i.e., concise, economical writing style) and comprehensiveness for clients with complex clinical pictures. Effectively communicates results verbally for complex cases; Reports integrate and explain seemingly

	psychometric constructs such as validity, reliability, and test construction	mental status examination)	population/ problem	clear expertise in classifying clients into DSM-V-V and/or ICD-1010 diagnostic codes; Is able to independently render a diagnostic impression that reflects a full understanding of the qualitative and quantitative features of DSM-V-V/ICD-1010 diagnostic criteria.	incorporating theory and case material for complex cases	contradictory information (i.e., test data that are not congruent with interview findings) and, when indicated, explain limitations of psychological methodologies.

Assessment

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	A) Measurement and Psychometrics:	B) Evaluation Methods:	C)Application of Methods:	D) Diagnosis:	E) Conceptualization and Recommendations:	F) Communication of Findings:
	Able to verbalize strengths and weaknesses of methodologies incorporated in the development of specific assessment procedures and uses this information, along with knowledge of psychometrics, in selecting and implementing, differing methods and means of evaluation. This is done in ways that are highly responsive to and respectful of diverse individuals, couples, families and groups and	Advanced knowledge of administration and scoring of traditional and specialized assessment measures, models and techniques, including clinical interviewing and mental status exam applied to complex cases	In the presence of highly complex clinical cases, creatively administers a wide variety of assessment tools and integrates results to accurately evaluate presenting question appropriate to the practice site and broad area of practice	Is able to establish accurate diagnoses in extremely complex cases and utilizes case formulation and diagnosis for intervention planning in the context of stages of human development and diversity	Independently and accurately conceptualizes the multiple dimensions of highly complex cases based on the results of assessment;	Demonstrates ability to communicate results in written and verbal form in a manner that integrates the needs of the reader and high levels of critical thinking.

	context					
Behavioral Anchor	Demonstrates knowledge and understanding of basic and advanced psychometric concepts by developing and validating new cognitive and/or noncognitive psychometric instruments.	Habitually and accurately administers and scores a wide range of assessment tools in the clinical setting in the presence of complex cases; Is able to perform and explain features of interview assessments of complex cases.	Demonstrates knowledge of and ability to base diagnosis and assessment on multiple sources of information within context of highly complex clinical cases; Demonstrates ability to determine appropriate selection of assessment measures for highly complex cases	Treatment plans integrate relevant developmental features and clinical symptoms as applied to presenting problems among clients with usually complex presentations; Demonstrates clear expertise in classifying clients into DSM-V and/or ICD-10 diagnostic codes and is able to explain differences and similarities between the two systems; Is able to independently render a diagnostic impression that reflects a full understanding of the qualitative and quantitative features of both DSM-V and ICD-10 diagnostic criteria.	Independently prepares reports based on assessment data for clients presenting with highly complex features/symptoms; Administers, scores and interprets test results in a manner that serves as a standard to be emulated by advanced practitioners; Formulates case conceptualizations incorporating theory and case material for highly complex cases Is sought after by colleagues and advanced practitioners for consultation diagnostic and case conceptualization issues	Writes reports that communicate complicated clinical material in a straight-forward manner and in a manner that 1.) presents conclusions in an explicit rather than implicit manner, and 2.) demonstrates the extent to which critical thinking and the integration of multiple data sources informed the writing. Communicates results verbally for complex cases in a manner that is appropriate for the understanding level of the addressee;

C. Intervention

Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations.

1.0 Readiness for Practicum

Essential Components	**A) Knowledge of Interventions:** Basic knowledge of scientific, theoretical, and contextual bases of intervention and basic knowledge of the value of evidence-based practice and it's role in scientific psychology	**B) Intervention planning:** Basic understanding of the relationship between assessment and intervention	**C) Skills:** Basic helping skills	**D) Intervention Implementation:** Basic knowledge of intervention strategies	**E) Progress evaluation:** Basic knowledge of the assessment of intervention progress and outcome
Behavioral Anchor	Articulates the relationship of EBP to the science of psychology; Identifies basic strengths and weaknesses of intervention	Articulates a basic understanding of how intervention choices are informed by assessment	Demonstrates helping skills, such as empathic listening, framing problems	Articulates awareness of theoretical basis of intervention and some general strategies	Demonstrates basic knowledge of methods to examine intervention outcomes

	approaches for different problems and populations				

Intervention

2.0 Readiness for Internship

Essential Components	**A) Knowledge of Interventions:** Demonstrates basic knowledge of scientific, theoretical, empirical and contextual bases of intervention, including theory, research, and practice	**B) Intervention planning:** Formulates and conceptualizes cases and plan interventions utilizing at least one consistent theoretical orientation	**C) Skills:** Clinical skills	**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)	**E) Progress evaluation:** Evaluates treatment progress and modify treatment planning as indicated, utilizing established outcome measures
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	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	Develops rapport with most clients; Develops therapeutic relationship; Demonstrates appropriate judgment about when to consult supervisor	Applies specific evidence-based interventions; Presents case that documents application of evidence-based practice	Assesses and documents treatment progress and outcomes; Alters treatment plan accordingly Describes instances of lack of progress and actions taken in response

	and client issues; Writes a statement of one's own theoretical perspective regarding intervention strategies				

Intervention

3.0 Readiness for Entry to Practice

Essential Components	**A) Knowledge of Interventions:** Applies knowledge of evidence-based practice, including empirical bases of intervention strategies, clinical expertise, and client preferences	**B) Intervention planning:** Independent intervention planning, including conceptualization and intervention planning specific to case and context	**C) Skills:** Clinical skills and judgment	**D) Intervention Implementation:** Implements interventions with fidelity to empirical models and flexibility to adopt where appropriate	**E) Progress evaluation:** Evaluates treatment progress and modifies planning as indicated, even in the absence of established outcome measures
Behavioral Anchor	Writes a case summary incorporating elements of evidence-based	Accurately assesses presenting issues taking into account the larger life context, including diversity	Develops rapport and relationships with a wide variety of clients;	Independently and effectively implements a typical range of intervention strategies appropriate	Independently assesses treatment effectiveness and efficiency; Critically evaluates own performance in the treatment role;

	practice; Presents rationale for intervention strategy that includes empirical support	issues; conceptualizes case independently and accurately; Independently selects an intervention or range of interventions appropriate for the presenting issues(s)	Uses good judgment about unexpected issues, such as crises, use of supervision, confrontation; Effectively delivers intervention	to practice settings; Independently recognizes and manages special circumstances; Terminates treatment successfully; Collaborates effectively with other providers or systems of care	Seeks consultation when necessary

Intervention

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Knowledge of Interventions:**	**B) Intervention planning:**	**C) Skills:**	**D) Intervention Implementation:**	**E) Progress evaluation:**
	Applies knowledge of , as well as limitations of, evidence-based practice, including empirical bases of intervention strategies contrasted with alternative treatment approaches; Exhibits clinical expertise in the execution of evidence-based	Evidences usually strong understanding of the relationship between case conceptualization and intervention planning.	Demonstrates empathy, , technical skills, and judgment.	Implements interventions with both high fidelity to empirical models and an appropriate degree of flexibility to adapt where appropriate.	Incorporates appropriate outcome measures for specifying treatment goals, progress toward goals, and goal attainment, even in the absence of established outcome measures for particular problems.

	procedures and treatment choices reflect client preferences.				
Behavioral Anchor	Via case presentations or professional writing articulates the relationship of EBP to the science of psychology; Identifies strengths and weaknesses of intervention approaches for different problems.	Case conceptualizations integrate the larger life context of clients, including diversity issues, with diagnostic features and the literature regarding evidence-based treatment; Provides comprehensive rationale for selection of specific interventions	Provides evidence of strong therapeutic relationships with nearly all clients. Uses sound judgment in handling crises.	Executes evidence-based treatments in a manner that maintains integrity with protocol requirements while simultaneously exhibiting the relationship-based common factors required of all therapeutic interventions;	When appropriate, uses metric-driven approach to clarify clinical problems, define treatment goals, and assess progress. When specific outcome measures are not available devises operationally defined measurements for treatment planning/assessment. Quantifies treatment effectiveness across wide categories of clients and treatment settings

Intervention

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Knowledge of Interventions:** Possesses and applies superior knowledge of scientific, theoretical, and contextual bases of intervention and exhibits advanced	**B) Intervention planning:** Sets professional standards for specifying relationships between case conceptualization and intervention planning	**C) Skills:** Exceptional integration of common factor skills, technical skills, and judgment .	**D) Intervention Implementation:** Serves as a model for advanced practitioners in maintaining both fidelity to empirical treatment models and flexibility in adapting to client needs	**E) Progress evaluation:** Incorporates appropriate outcome measures across multiple clients and provides empirical summary of client improvement. Via accumulated outcome data is able to specify differential treatment effectiveness based on client characteristics, diversity

	knowledge of the value of evidence-based practice and it's basis within in scientific psychology.				status, and other parameters in a manner that leads to modifications in treatment, as needed.
Behavioral Anchor	Actively engages in the creation of evidence-based interventions from pilot stage to formal recognition in the literature of the value of the created interventions.	Establishes validated protocols for specifying relationships between client variables and intervention strategies.	Demonstrates and teaches others sophisticated and highly advanced skills, such as empathic listening, framing problems, with particularly difficult patients.	Is sought after by advanced practitioners to model evidence-based treatments and to explain the rationale for adaptations made to such to meet needs of specific clients.	Demonstrates skilled knowledge of methods to examine intervention outcomes, consistently utilizes outcomes in practice and is sought by peers for guidance Demonstrates sound understanding of methods to examine intervention outcomes

D. Research/Evaluation

Generating research that contributes to the professional knowledge base and/or evaluates the effectiveness of various professional activities.

1.0 Readiness for Practicum

Essential Components	**A) Scientific Approach to Knowledge Generation:** Basic scientific mindedness, critical thinking.	**B) Application of Scientific Method to Practice:** No expectations for pre-practicum level
Behavioral Anchor	Demonstrates understanding that psychologists evaluate the effectiveness of their professional activities. Open to scrutiny of one's work by peers and faculty	

Research/Evaluation

2.0 Readiness for Internship

Essential Components	**A) Scientific Approach to Knowledge Generation:** Develops skills in seeking, applying, and evaluating theoretical and research knowledge relevant to the practice of psychology.	**B) Application of Scientific Method to Practice:** Uses scientific methods to evaluate own practice.
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	Demonstrates familiarity with evidence based practices; Compiles and analyzes data on own clients (outcome measurement); participates in program evaluation

Research/Evaluation

3.0 Readiness for Entry to Practice

Essential Components	**A) Scientific Approach to Knowledge Generation:** Contributes to knowledge base of practice.	**B) Application of Scientific Method to Practice:** Evaluates outcomes using evidence-based principles.
Behavioral Anchor	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.	Evaluates the progress of own activities and uses this information to improve own effectiveness; Describes how outcomes are measured in each practice activity.

Research/Evaluation

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Scientific Approach to Knowledge Generation:** Generates new knowledge in field..	**B) Application of Scientific Method to Practice:** Integrates scientific knowledge into clinical practice.
Behavioral Anchor	Independently contributes to the knowledge base of psychology.	Consistently accesses scientific knowledge base and integrates scientific knowledge into clinical work.

Research/Evaluation

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Scientific Approach to Knowledge Generation:** Generates significant knowledge in field of psychology.	**B) Application of Scientific Method to Practice:** Makes significant contribution to clinical practice field.
Behavioral Anchor	Creates new methodology based upon finding of sentinel research. Teaches/Presents findings.	Contribute to a practice database. Author texts/articles that is useful in both didactic and experiential curricula.

E. Supervision

Supervision and training in the professional knowledge base and of evaluation of the effectiveness of various professional activities.

1.0 Readiness for Practicum

Essential Components	**A) Expectation and Roles:** Basic knowledge of expectations	**B) Processes and Procedures:** Knowledge of	**C) Skills Development:** Interpersonal skills of communication	**D) Awareness of factors affecting quality:** Basic knowledge of	**E) Participation in Supervision Process:** Awareness of	**F) Ethical and Legal Issues:** Knowledge of principles of ethical practice and

	for supervision	basic processes and procedures	and openness to feedback	and sensitivity to issues related to individual and cultural differences (i.e., the APA definition) related to the supervision process and relationship	need for straightforward, truthful, and respectful communications in supervisory relationship	basic skills in supervisory ethical decision-making, knowledge of legal and regulatory issues and supervision
Behavioral Anchor	Demonstrates knowledge of the process of supervision	Demonstrates basic knowledge of supervision models and practice	Complete self-assessment (e.g., Hatcher and Lassiter, 2006) Integrates faculty/supervisor feedback into self-assessment	Demonstrates basic knowledge of literature on individual and cultural differences and engages in respectful interactions that reflect that knowledge	Demonstrates willingness to admit errors, accept feedback	Demonstrates understanding of this knowledge (e.g., APA 2010 ethical principles)

Supervision

2.0 Readiness for Internship

Essential Components	**A) Expectation and Roles:** Knowledge of purpose for and roles in supervision	**B) Processes and Procedures:** Knowledge of procedures and processes of supervision	**C) Skills Development:** Knowledge of the supervision literature and how clinicians develop to be skilled professionals	**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	**E) Participation in Supervision Process:** Observation of and participation in supervisory process (e.g., peer supervision)	**F) Ethical and Legal 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

				of personal contribution to therapy and the supervision		
Behavioral Anchor	Identifies roles and responsibilities of the supervisor and supervisee in the supervision process	Identifies goals and tasks of supervision; Tracks progress achieving goals and setting new goals	Successfully completes coursework on supervision; Demonstrates formation of supervisory relationship integrity theory and skills including knowledge of development, educational praxis	Demonstrates knowledge of ICD literature and APA guidelines in supervision practice; Demonstrates awareness of role of oppression and privilege on supervision process	Reflects on supervision process, areas of strength, and areas needing improvements; Seeks supervision to improve performance, presenting work for feedback, and integrating feedback into performance	Behaves ethically; Recognizes ethical and legal issues in clinical practice and supervision

Supervision

3.0 Readiness for Entry to Practice

Essential Components	A) Expectation and Roles:	B) Processes and Procedures:	C) Skills Development:	D) Awareness of factors affecting quality:	E) Participation in Supervision Process:	F) Ethical and Legal Issues:
	Understands complexity of the supervisory role including ethical, legal and contextual issues	Demonstrates knowledge of procedures and practices of supervision	Engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients	Demonstrates understanding of intersecting dimensions of diversity in the context of supervision practice, able to engage in reflection on the role of self in therapy and in supervision	Provides supervision independently to others in routine cases	Command of and application of relevant ethical, legal, and professional standards and guidelines
Behavioral Anchor	Articulates a philosophy or model of supervision and reflects on how this model is applied in practice	Independently prepares supervision contract; Demonstrates advanced knowledge of limits of competencies to supervise (assessed metacompetency); Independently constructs plan to deal with areas of limited competency	Clearly articulates how to use supervisory relationships to promote development of supervisees and their clients	Demonstrates integrity of diversity and multiple identity aspects in conceptualizations of supervision process with all participates (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; Routinely incorporates diversity issues into supervisory process; Identifies impact of aspects of self in therapy and supervision	Provides supervision to less advanced trainees, peers or other service providers in typical cases appropriate to the service setting	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

Supervision 4.0 Readiness For Fully Autonomous Practice

Essential Components	**A) Expectation and Roles:** Fully understands complexity of the supervisory role including ethical, legal, and contextual issues	**B) Processes and Procedures** Demonstrates advanced knowledge of procedures and practices of supervision	**C) Skills Development:** Fully engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients	**D) Awareness of factors affecting quality:** Demonstrates advanced understanding of intersecting dimensions of diversity in the context of supervision practice, able to engage in reflection on the role of self in therapy and in supervision	**E) Participation in Supervision Process:** Provides supervision independently to others on complex cases	**F) Ethical and Legal Issues:** Demonstrates advanced knowledge of and application of relevant ethical, legal, and professional standards and guidelines
Behavioral Anchor	Clearly articulates a philosophy or model of supervision and reflects on how this model is applied in practice, including integrated contextual, legal, and ethical perspectives.	Independently prepares supervision contract; Demonstrates advanced knowledge of limits of competencies to supervise (assessed metacompetency); Independently constructs plan to deal with areas of limited competency	Clearly articulates how to use supervisory relationships to leverage development of supervisees and their clients	Skillfully incorporates awareness and discussion of diversity variables into all aspects of supervision process; 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; Identifies impact of aspects of self in therapy and supervision	Provides supervision to advanced trainees, peers or other service providers in typical and complex cases appropriate to the service setting	Habitually 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 and creates plan to resolve issues when they arise.

Supervision

5.0 Readiness for Life-long Learning/Master Clinician

Essential Components	**A) Expectation and Roles:** Demonstrates superior understanding of complexity of the supervisory role including ethical, legal, and contextual issues	**B) Processes and Procedures:** Shows high level of knowledge regarding procedures and practices of supervision	**C) Skills Development:** Habitually engages in professional reflection about one's clinical relationships with supervisees, as well as supervisees' relationships with their clients	**D) Awareness of factors affecting quality:** Thoroughly understands intersecting dimensions of diversity in the context of supervision practice, able to engage in reflection on the role of self in therapy and in supervision	**E) Participation in Supervision Process:** Consistently provides supervision independently to others in routine and complex cases	**F) Ethical and Legal Issues:** Skillfully applies relevant ethical, legal, and professional standards and guidelines
Behavioral Anchor	Masterfully articulates a philosophy or model of supervision and reflects on how this model is applied in practice, including integrated contextual, legal, and ethical perspectives	Adeptly prepares supervision contract; Demonstrates expert knowledge of limits of competencies to supervise (assessed metacompetency); Constructs plan to deal with areas of limited competency	Masterfully articulates how to use supervisory relationships to leverage development of supervisees and their clients	Masterfully demonstrates integrity of diversity and multiple identity aspects in conceptualizations of supervision process with all participates (client(s), supervisee, supervisor); Demonstrates adaptation of own professional behavior in a culturally sensitive manner as	Skillfully provides supervision to advanced trainees, peers or other service providers in typical cases appropriate to the service setting; is sought after by peers for supervision in complex cases	Masterfully identifies complex ethical and legal issues in supervision, and analyzes and proactively addresses them; Demonstrates keen awareness of potential conflicts and complex ethical and legal issues in supervision

				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		

F. Teaching

Providing instruction, disseminating knowledge, and evaluating acquisition of knowledge and skill in professional psychology.

1.0 Readiness for Practicum

Essential Components	**A) Knowledge:** Demonstrates awareness of theories and how they impact teaching	**B) Skills:** Knowledge of application of teaching methods
Behavioral Anchor	Observes differences in teaching styles and need for response to different learning skills	Demonstrates example of application of teaching methods; Demonstrates ability to organize and present information related to a topic

Teaching

2.0 Readiness for Internship

Essential Components	**A) Knowledge:** Demonstrates knowledge of didactic teaching strategies and how to accommodate developmental and individual differences	**B) Skills:** Applies of teaching methods in multiple settings
Behavioral Anchor	Demonstrates knowledge of one learning strategy. Demonstrates clear communication skills	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

Teaching

3.0 Readiness for Entry to Practice

Essential Components	**A) Knowledge:** Knowledge of outcome assessment of teaching effectiveness	**B) Skills:** Evaluation of effectiveness of learning/teaching strategies addressing key skill sets
Behavioral Anchor	Demonstrates knowledge of one technique of outcome assessment. Demonstrates knowledge of methodological considerations in assessment of teaching effectiveness	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

Teaching

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Knowledge:** Advanced knowledge of application of teaching methods	**B) Skills:** Exhibits advanced ability to evaluate effectiveness of learning/teaching strategies in addressing key skill sets
Behavioral Anchor	Demonstrates ability to apply numerous teaching methods. Demonstrates ability to organize and present information related to a number of advanced level topics	Demonstrates strategies to evaluate teaching effectiveness of targeted skill sets; Demonstrates ability to articulate concepts to be taught and research/empirical support; Demonstrates evaluation strategies to assess learning objectives

Teaching

5.0 Readiness for Live-Long learning/Master Clinician

Essential Components	**A) Knowledge:** Superior knowledge of application of teaching methods	**B) Skills:** Superior ability to evaluate effectiveness of learning/teaching strategies addressing key skill sets
Behavioral Anchor	Demonstrates multiple examples of applications of teaching methods; Demonstrates ability to organize and present complex information to a variety of audiences	Demonstrates superior ability to develop strategies to evaluate teaching effectiveness of targeted skill sets; articulation of complex concepts to be taught and research/empirical support; demonstrates advanced evaluation strategies to assess learning objectives

II. 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.

1.0 Readiness for Practicum

Essential Components	**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:** Knowledge, awareness, and understanding of one's own dimensions of diversity and attitudes towards diverse others	**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:** Knowledge, awareness, and understanding of other individuals as cultural beings	**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:** Knowledge, awareness, and understanding of interactions between self and diverse others	**D) Applications based on individual and cultural context:** Basic knowledge of and sensitivity to the scientific, theoretical, and contextual issues related to the ICD (as defined by APA policy) as they apply to professional psychology. Understanding of the need to consider ICD issues in all aspects of professional psychology work (e.g., assessment, treatment, research, relationships with colleagues)
Behavioral Anchor	Demonstrates this self-knowledge,	Demonstrates knowledge, awareness and	Demonstrates knowledge, awareness and understanding	Demonstrates basic knowledge of literature on individual and cultural differences and

	awareness, and understanding. For example: articulates how ethnic group values influenced who one is and how one relates to other people	understanding of the way culture and context shape the behavior of other individuals	of the way culture and context shape interactions between and among individuals	engages in respectful interactions that reflects this knowledge; Demonstrates understanding of the need to consider ICD issues in all aspects of professional psychology work through respectful interactions

Individual and Cultural Diversity

2.0 Readiness for Internship

Essential Components	**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	**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	**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	**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	Understands and monitors own	Understands multiple cultural identities and	Understands the role of multiple cultural identities	Demonstrates knowledge of ICD literature and APA policies including guidelines for

	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	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	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	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

Individual and Cultural Diversity

3.0 Readiness for Entry to Practice

Essential Components	**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:** Independently monitors and applies knowledge of own	**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:** Independently monitors and applies knowledge of others‘ cultural identities in assessment, treatment, and consultation	**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:** Independently monitors and applies knowledge of intersection between therapist and patient cultural identities in assessment, treatment, and	**D) Applications based on individual and cultural context:** Applies knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity (for example, the relationship between one's own dimensions of diversity and one's attitudes towards diverse others) to professional work

	cultural identity in assessment, treatment, and consultation		consultation	
Behavioral Anchor	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 or supervision when uncertain about diversity issues	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	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	Articulates an integrative conceptualization of diversity as it impacts clients, self and others (e.g., organizations, colleagues, systems of care); 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

Individual and Cultural Diversity

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Self as shaped by individual and cultural diversity and context:** Independently and consistently monitors and applies knowledge of self as a cultural	**B) Others as shaped by individual and cultural diversity and context:** Independently and consistently monitors and applies knowledge of others as cultural beings in assessment, treatment, and	**C) Interaction of self and others as shaped by individual and cultural diversity and context:** Independently and consistently monitors and applies knowledge of diversity in the others as cultural beings in	**D) Applications based on individual and cultural context:** Skillfully applies knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity; for example, the relationship between one's own dimensions of diversity and one's own attitudes towards diverse others to professional work

	being in assessment, treatment, and consultation	consultation	assessment, treatment, and consultation	
Behavioral Anchor	Consistently articulates understands, and monitors own cultural identity in relation to work with others; Habitually uses knowledge of self to monitor and improve effectiveness as a professional; Frequently critically evaluates feedback and initiates consultation or colleagues when uncertain about diversity issues	Articulates an integrative conceptualization of diversity as it impacts clients, self and others (e.g., organizations, colleagues, systems of care); 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 with knowledgeable colleagues regarding individual and cultural diversity when relevant	Insightfully and clearly articulates, understands, and monitors multiple cultural identities in interactions with others; Habitually uses knowledge of the role of culture in interactions to monitor and improve effectiveness as a professional; Frequently critically evaluates feedback and initiates consultation with a knowledgeable colleague when uncertain about diversity issues with others	Insightfully and clearly articulates an integrative conceptualization of diversity as it impacts clients, self and others (e.g., organizations, colleagues, systems of care); 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 skillfully uses alternative and culturally appropriate repertoire of skills and techniques and behaviors; Habitually seeks consultation regarding addressing individual and cultural diversity as needed; Consistently uses culturally relevant best practices

Individual and Cultural Diversity

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Self-Awareness:** **Independently monitors and applies knowledge of self as a cultural being in assessment, treatment, and consultation**	**B) Applied Knowledge:** **Applies knowledge, skills, and attitudes regarding intersecting and complex dimensions of diversity (e.g. age, gender, enculturation, sexual orientation) to professional work**	**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:**	**D) Applications based on individual and cultural context:**
Behavioral Anchor	Consistently, spontaneously, and skillfully able to articulate, understand, and monitor own cultural identity in relation to work with complex situations ; Continuously uses knowledge of self to monitor and improve effectiveness as a professional; Is sought after for feedback and consultation or	Eloquently articulates an integrative conceptualization of diversity as it impacts clients, self and others (e.g., organizations, colleagues, systems of care); Seamlessly adapts one's professional behavior in a culturally sensitive manner, as appropriate to the needs of the client, and demonstrates improvement in client outcomes. Consistently avoids harm	Habitually, insightfully and clearly articulates, understands, and monitors multiple cultural identities in interactions with others even in extremely challenging situations; Continuously uses knowledge of the role of culture in interactions to monitor and improve effectiveness as a professional; Frequently provides consultation and supervision to others regarding diversity issues	Eloquently articulates an integrative conceptualization of diversity as it impacts clients, self and others (e.g., organizations, colleagues, systems of care); Consistently and skillfully 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; Promotes development and use of alternative and culturally appropriate repertoire of skills and techniques and behaviors; Sought after for consultation regarding addressing individual and cultural diversity as needed; Consistently uses culturally relevant best

	supervision by peers and or members of the community			practices

III. 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.

1.0 Readiness for Practicum

Essential Components	**A) Knowledge of ethical, legal and professional standards and guidelines:** Basic knowledge of the principles of the APA Ethical Principles and Code of Conduct (ethical practice in basic skills in ethical decision-making); beginning knowledge of legal and regulatory issues in the practice of psychology that apply to practice while placed at practicum setting.	**B) Awareness and Application of Ethical Decision Making:** Demonstrates the importance of an ethical decision model applied to practice	**C) Ethical Conduct:** Ethical attitudes and values evident in conduct
Behavioral Anchor	Displays a basic understanding of this knowledge (e.g., APA Ethics Code and principles, Ethical Decision Making Models); Demonstrates knowledge of typical legal issues (e.g., child and elder abuse reporting, HIPAA, Confidentiality, Informed	Recognizes the importance of basic ethical concepts applicable in initial practice (e. g., child abuse reporting, Informed consent, confidentiality, multiple relationships, and competence); Identifies potential conflicts between personal belief systems, APA ethics	Evidences desire to help others; Demonstrates openness to new ideas; Shows honesty/integrity/values in ethical behavior; Demonstrates personal courage consistent with ethical values of psychologists;

	Consent)	code and legal issues in practice	Displays a capacity for appropriate boundary management; Implements ethical concepts into professional behavior

Ethical Legal Standards and Policy

2.0 Readiness for Internship

Essential Components	**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	**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	**C) Ethical Conduct:** Knowledge of own moral principles/ethical values integrated in professional conduct
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	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	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

Ethical Legal Standards and Policy

3.0 Readiness for Entry to Practice

Essential Components	**A) Knowledge of ethical, legal and professional standards and guidelines:** Demonstrates 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	**B) Awareness and Application of Ethical Decision Making:** Demonstrates commitment to integration of ethics knowledge into professional work	**C) Ethical Conduct:** Independently and consistently integrates ethical and legal standards into all facets of professional behavior.
Behavioral Anchor	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	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	Integrates an understanding of ethical-legal standards policy into professional behavior; Demonstrates awareness that ethical-legal standards policies competence informs and is informed by all facets of professional behavior; Takes responsibility for continuing professional development

Ethical Legal Standards and Policy

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Knowledge of ethical, legal and professional standards and guidelines:** Habitually utilizes the application of the APA Ethical Principles and Code of Conduct and other relevant ethical, legal and professional standards and guidelines of the profession	**B) Awareness and Application of Ethical Decision Making Model** Applies an ethical decision making model in integrating ethics knowledge into professional work	**C) Ethical Conduct** Proactively models and teaches the integration of ethical/legal standards policy into all facets of professional behavior.
Behavioral Anchor	Consistently, spontaneously and reliably identifies complex ethical & legal issues, analyzes them accurately and proactively addresses them; Aware of and avoids potential conflicts in complex ethical and legal issues and seeks to prevent problems and unprofessional conduct; Appropriately confronts peers and or organizations regarding ethical problems or issues and deals proactively with conflict when addressing professional behavior with others	Consistently includes ethics in professional writings of diverse topics; Consistently applies ethics concepts in research design and subject treatment; Consistently includes ethics and professional concepts in teaching and training activities; Develops strategies to seek and provide consultation regarding complex ethical and legal dilemmas	Consistently integrates behavior of ethical-legal-standards policy when into professional behavior; Demonstrates that ethical-legal-standards policy competence informs and is informed by all facets of professional behavior; Takes responsibility for continuing professional development of knowledge, skills, and attitudes in relation to ethical-legal-standards and policies; Teaches these standards to subordinates/ junior practitioners.

Ethical Legal Standards and Policy

5.0 Readiness for Lifelong Learning/Master clinician

Essential Components	**A) Knowledge of ethical, legal and professional standards and guidelines:** Habitually applies the APA Ethical Principles and Code of Conduct and other relevant and other ethical, legal and professional standards and guidelines of the profession in all situations.	**B) Awareness and Application of Ethical Decision Making Model** Skillfully integrates ethics knowledge into all aspects of personal and professional work	**C) Ethical Conduct** Sets the highest standard in integrating ethical/legal standards policy with all foundational and functional competencies; Provides training and effectively models ethical conduct to all disciplines
Behavioral Anchor	Habitually, consistently, spontaneously, and reliably identifies complex ethical & legal issues, analyzes them accurately and proactively addresses them; avoids all potential conflicts in complex ethical and legal issues and prevents problems and unprofessional conduct; adequately and professionally confronts peers and or organizations regarding ethical problems or issues and empowers others to appropriately deal with conflict when addressing professional behavior in others	Skillfully incorporates ethics in professional writings and presentations; models the incorporation of ethics concepts in research design and subject treatment; always includes ethics and professional concepts in teaching and training activities; develops strategies and empowers others to teach others to seek ways and provide consultation regarding complex ethical and legal dilemmas	Skillfully integrates ethical- legal-standards policy when performing all professional behavior; Empowers others to continue professional development of knowledge, skills, and attitudes in relation to ethical-legal-standards and policies; Holds subordinates/ junior practitioners, and peers accountable for the standards.

Program Specific Competencies

I. Consultation and Advocacy

A. Interdisciplinary Systems

Knowledge of key issues and concepts in related disciplines. Identify and interact with professionals in multiple disciplines. **Developmental Level**

1.0 Readiness for Practicum

Essential Components	**A) Knowledge of the shared and distinctive contributions of other professions.** Beginning, basic knowledge of the viewpoints and contributions of other professions/professionals	**B) Functioning in multidisciplinary and interdisciplinary contexts:** Cooperation	**C) Understands how participation in interdisciplinary collaboration/ consultation enhances outcomes:** Knowledge of how participating in interdisciplinary collaboration/ consultation can be directed toward shared goals	**D) Respectful and productive relationships with individuals from other professions:** Awareness of the benefits of forming collaborative relationships with other professionals
Behavioral Anchor	Demonstrates knowledge, respect, and valuing of roles, functions and service delivery systems of other professions	Demonstrates ability to cooperate with others in task completion	Demonstrates understanding of concept	Expresses interest in developing collaborative relationships and respect for other professionals

Interdisciplinary Systems

2.0 Readiness for Internship

Essential Components	**A) Knowledge of the shared and distinctive contributions of other professions:**	**B) Functioning in multidisciplinary and interdisciplinary contexts:**	**C) Understands how participation in interdisciplinary collaboration/ consultation enhances outcomes:**	**D) Respectful and productive relationships with individuals from other professions:**
	Demonstrates wareness 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	Demonstrates beginning knowledge of strategies that promote interdisciplinary collaboration versus multidisciplinary functioning	Demonstrates k1nowledge of how participating in interdisciplinary collaboration/consultation can be directed toward shared goals Participates in and initiates interdisciplinary collaboration/consultation directed toward shared goals	Demonstrates awareness of the benefits of forming collaborative relationships with other professionals Develops and maintains collaborative, respectful relationships with other professionals

Behavioral Anchor	Reports observations of commonality and differences among professional roles, values, and standards Demonstrates ability to articulate the role that others provide in service to clients Displays ability to work successfully on interdisciplinary team	Demonstrates knowledge of the nature of interdisciplinary vs. multidisciplinary function and the skills that support interdisciplinary process	Demonstrates understanding of concept Consults with and cooperates with other disciplines in service of clients	Expresses interest in developing collaborative, respectful relationships with other professionals Communicates effectively with individuals from other professions

Interdisciplinary Systems

3.0 Readiness for Entry to Practice

Essential Components	**A) Knowledge of the shared and distinctive contributions of other professions:** Shows working knowledge of multiple and differing worldviews, professional standards, and contributions across contexts and systems, demonstrates intermediate level knowledge of common and distinctive roles of other professionals	**B) Functioning in multidisciplinary and interdisciplinary contexts:** Shows 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, and supporting and utilizing the perspectives of other team members	**C) Understands how participation in interdisciplinary collaboration/ consultation enhances outcomes:** Recognizes and engages in opportunities for effective collaboration with other professionals toward shared goals at an intermediate level of ability	**D) Respectful and productive relationships with individuals from other professions:** Develops and maintains collaborative relationships over time despite differences in professional roles
Behavioral Anchor	Demonstrates ability to articulate the role that others provide in service to clients; Demonstrates ability to work successfully on interdisciplinary team	Demonstrates skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation	Systematically collaborates successfully with other relevant partners	Communicates effectively with individuals from other professions; Appreciates and integrates perspectives from multiple professions

Interdisciplinary Systems

1.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Knowledge of the shared and distinctive contributions of other professions:** Shows in depth knowledge of multiple and differing worldviews, professional standards, and contexts and systems, advanced level knowledge of common and distinctive roles of other professionals	**B) Functioning in multidisciplinary and interdisciplinary contexts:** Demonstrates in depth knowledge of and ability to display skills that support effective interdisciplinary team functioning, including communicating information in a clear and professional manner, assisting the team in resolving disagreements in diagnosis and treatment goals, and eliciting and using perspectives of other team members.	**C) Understands how participation in interdisciplinary collaboration/ consultation enhances outcomes:** Recognizes and engages in opportunities for effective collaboration with other professionals toward shared goals.	**D) Respectful and productive relationships with individuals from other professions:** Develops supports, and advances collaborative relationships across time with differing disciplines
Behavioral Anchor	Demonstrates in depth understanding of the role that colleagues, professionals from other disciplines, and community resources provide in service to clients; demonstrates ability to work as an integral member of an interdisciplinary team	Demonstrates advanced skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation.	Actively facilitates the collaborative activities of relevant team members	Demonstrates and facilitates effective communication with individuals from other professions; is able to articulate and integrate perspectives from multiple professions

Interdisciplinary Systems

2.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Knowledge of the shared and distinctive contributions of other professions:** Expert knowledge of multiple and differing worldviews, standards, and contexts and systems; superior knowledge of common and distinctive roles of other professionals	**B) Functioning in multidisciplinary and interdisciplinary contexts:** Expert knowledge of multidisciplinary and interdisciplinary team functioning; expert understanding of communication techniques to promote understanding of different perspectives and to promote conflict resolution when appropriate	**C) Understands how participation in interdisciplinary collaboration/ consultation enhances outcomes:** Expert ability to develop and expand opportunities for collaborative professional relationships	**D) Respectful and productive relationships with individuals from other professions:** Adept at identifying strengths and commonalities that facilitate working together in the face of opposition and differing opinion
Behavioral Anchor	Is sought after by colleagues, professionals from other disciplines, and community leaders for advice and training in developing interdisciplinary teams	Develops models and standards for developing multidisciplinary and interdisciplinary teams and techniques for enhancing their effectiveness.	Develops and promotes clinical skills in team members through training activities, case conferences, research projects, and outcome measures	Encourages and participates in healthy and respectful discourse for the advancement of the field

B. Consultation

The ability to provide expert guidance or professional assistance in response to a client's needs or goals.

1.0 Readiness for Practicum

Essential Components	**A) Role of consultant:** No expectation for prepracticum level	**B) Addressing Referral Question:** No expectation for prepracticum level	**C) Communication of Findings:** No expectation for prepracticum level	**D) Application of Methods:** No expectation for pre-practicum level
Behavioral Anchor		↓	↓	

Consultation

2.0 Readiness for Internship

Essential Components	**A) Role of Consultant:** Demonstrates awareness of the consultant's role and its unique features as distinguished from other professional roles such as therapists, supervisor, teacher).	**B) Addressing Referral Question:** Demonstrates knowledge of and ability to select appropriate means of assessment to answer referral questions	**C) Communication of Findings:** Identifies literature and knowledge about process of informing consultee of assessment findings	**D) Application of Methods:** Identifies and acquires literature relevant to unique consultation methods (assessment and intervention) within systems, clients or settings

Behavioral Anchor	Articulates common and distinctive roles of consultant;	Implements systematic approach to data collection in a consultative role;	Identifies appropriate approaches and processes for providing written and verbal feedback and recommendation to consultee.	Identifies appropriate interventions based on consultation assessment findings

	Compares and contrasts consultation, clinical and supervision roles	Identifies sources and types of assessment tools		

Consultation

3.0 Readiness for Entry to Practice

Essential Components	**A) Role of Consultant:** Determines situations that require different role functions and shift roles accordingly	**B) Addressing Referral Question:** Selects contextually and culturally sensitive means of assessment/data gathering that answer consultation referral question	**C) Communication of Findings:** Provides effective assessment feedback and articulates appropriate recommendations	**D) Application of Methods:** Applies literature to provide effective consultative services (assessment and intervention) in most routine and some complex cases
Behavioral Anchor	Recognizes situations in which consultation is appropriate; Demonstrates capability to shift functions and behavior to meet referral meets	Demonstrates ability to gather information necessary to answer referral questions; Clarifies and refines referral question based on analysis/assessment of question and on awareness of relevant diversity factors	Prepares clear, useful consultation reports and recommendations to all parties; Provides verbal feedback to consultee of results and offers recommendations	Identifies and implements consultation interventions based on assessment findings; Identifies and implements consultation interventions that meet consultee goals

Consultation

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Role of Consultant:** Skillfully determines situations that require different role functions and adeptly shifts roles accordingly	**B) Addressing Referral Question:** Demonstrates advanced knowledge and consistent ability to select appropriate and contextually and	**C) Communication of Findings:** Skillfully, promptly, and effectively provides assessment feedback that demonstrates advanced	**D) Application of Methods:** Applies literature to provide effective consultative services (assessment and intervention) in all routine and most complex cases
		culturally sensitive means of assessment/data gathering that answers the consultation referral question.	knowledge and leads to highly appropriate recommendations	
Behavioral Anchor	Ability to shift functions, roles and behavior to meet referral needs, ability to determine "what is needed" and "that which is requested"- renegotiating service parameters with referral source.	Integrates multiple sources of data, as appropriate for the situation, to answer referral question Refines consultation efforts via ongoing analysis of referral question, incorporating relevant diversity factors	Prepares consultation reports and recommendations that reflect the integration of a sophisticated problem analysis, systematic data collection, and critical thinking. Provides verbal feedback to consultee of results in a manner that matches the complexity of information shared with the level of sophistication exhibited by the consultee for understanding the feedback	Demonstrates innovative ability to identify and implement consultation interventions based on assessment findings; Exhibits knowledge of clinical research in the area of consultation

Consultation

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Role of Consultant:** **Skillfully determines situations that require different role functions and shifts roles accordingly**	**B) Addressing Referral Question:** **Shows consistent ability to select appropriate and contextually and culturally sensitive means of assessment/data gathering that answers**	**C) Communication of Findings:** Skillfully, promptly, and effectively provides assessment feedback that demonstrates advanced knowledge and leads to highly useful and relevant recommendations	**D) Application of Methods:** **Proficiently applies methodology from recent literature in an effort to provide effective consultative services in most routine and some complex cases**
		consultation referral question		

Behavioral Anchor	Routinely recognizes when a consult by another professional/ discipline would be more appropriate; demonstrates expert and ability to shift functions and roles and behavior to meet referral needs to an extent beyond that usually seen in peers; consultation and/or deferrals conducted with referral source satisfaction; when multiple clients exist within the context of a single referral, is able to clarify role, maintain boundaries and communicate/ consult appropriately and ethically across clients such that referral source/ client(s) are optimally satisfied; makes valuable profession contributions in the consultative practice area within present healthcare system, surrounding local and/or national community/professional arenas; considered by local/national peers and/or systems as an expert.	Provides = expert integration and analysis of referral question; quick pursuit and efficient utilization of relevant data sources given said analysis; considers and supports optimal intervention in relevant biopsychosocial processes; meets client needs and goals through a professional psychological consultation product; is sensitive to systemic, cultural and political realities/demands of the consultative milieu; is seen by client(s) as providing clinical and expert value beyond that only related to addressing referral question; is considered by peers and systems as expert.	Skillfully provides feedback (both verbal and written) in a concise and articulate manner; anticipating questions, providing explanation when necessary	Prepares consultation reports considered by referral source/ client as authoritative; communicates recommendations in a clear and precise manner to all appropriate parties given context of service provision; commanding knowledge of clinical research in consultation interest area; thought by client/referral source to be outstandingly competent, informative and skilled; provides more than just consultation but shares clinical knowledge and decision process in a nonthreatening manner as appropriate; is highly sought out in the present heath care system and/or the local/national community for consultative expertise and knowledge.

C. Relationships

Form effective and meaningful relationships with individuals, groups, and/or communities.

1.0 Readiness for Practicum

Essential Components	**A) Interpersonal Relationships:** Interpersonal skills	**B) Affective Skills:** Affective skills	**C) Expressive Skills:** Expressive skills
Behavioral Anchor	Listens and is emphatic with others; Respects and shows interest in others' cultures, experiences, values, points of view, goals and desires, fears, etc.; Demonstrates skills verbally and non-verbally; Receives open to feedback	Demonstrates affect tolerance; Tolerates and understands interpersonal conflict; Tolerates ambiguity and uncertainty; Demonstrates awareness of inner emotional experience; Demonstrates emotional maturity; Listens to and acknowledges feedback from others	Appropriately communicates ideas, feelings and information verbally and non-verbally

Relationships

2.0 Readiness for internship

Essential Components	**A) Interpersonal Relationships:**	**B) Affective Skills:**	**C) Expressive Skills:** Clear and articulate expression
	Forms and maintains productive and respectable relationships with clients, peer/colleagues, supervisors and professionals from other disciplines	Negotiates differences and handles conflict satisfactorily; provides effective feedback to others and receives feedback nondefensively	
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	Works collaboratively; Demonstrates active problemsolving; 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 nondefensively	Communicates clearly using verbal, nonverbal and written skills; Demonstrates understanding of professional language

Relationships

3.0 Readiness for entry to practice

Essential Components	**A) Interpersonal Relationships:** Develops and maintains effective relationships with a wide range of clients,	**B) Affective Skills:** Manages difficult communications; possesses advanced interpersonal skills	**C) Expressive Skills:** Effective command of language and ideas
	colleagues, organizations and communities		
Behavioral Anchor	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	Seeks clarifications in challenging interpersonal communications; Demonstrates understanding of diverse viewpoints in challenging interactions; Accepts, evaluates and implements feedback from others	Demonstrates descriptive, understandable command of language, both written and verbal; Communicates clearly and effectively with clients

Relationships

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Interpersonal Relationships:** Develops and maintains highly effective relationships with a wide range of clients, colleagues, organizations and communities	**B) Affective Skills:** Manages particularly difficult communication; possesses clearly advanced interpersonal skills	**D) Expressive Skills** Exhibits highly articulate and command of language and ideas

Behavioral Anchor	Negotiates highly conflictual, difficult and complex relationships including those with individuals and groups that differ significantly from oneself; Maintains strong interpersonal relationships with clients, peers,	Routinely seeks clarification in interpersonal communications in a manner that minimizes prospects for conflict; Demonstrates understanding of =diverse viewpoints;	Shows high level command of language, both written and verbal; Able to communicate clearly and effectively with clients, colleagues, and referral sources
	faculty, allied professionals, and the public	Seeks feedback from others and demonstrates ability to utilize such	

Relationships

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Interpersonal Relationships** **Develop and maintain effective relationships with an extremely wide range of clients, colleagues, organizations and communities**	**B) Affective Skills** **Ability to manage difficult communication; possess exceptional interpersonal skills**	**E) C) Expressive Skills** **Outstanding command of expressive language skills and the communication of complex ideas**

Behavioral Anchor	Functions as a highly sought after negotiator for situations characterized by highly conflictual, difficult and complex relationships among individuals from highly diverse settings representing major governmental and nongovernmental agencies and organizations; maintain exceptionally strong interpersonal relationships with clients, peers, faculty, allied professionals, the public, and agents from international organizations	Habitually seeks clarification in interpersonal communications in a manner that characteristically leads to harmonious discourse; demonstrates exceptional understanding of widely diverse viewpoints; characteristically seeks feedback from others and demonstrates clear ability to utilize such feedback	Remarkably descriptive, understandable command of language, both written and verbal; able to communicate clearly and effectively with clients, colleagues, referral sources, the mass media, national and international foundations, and elected government representatives.

D. Advocacy

Actions targeting the impact of social, political, economic or cultural factors to promote change at the individual (client), institutional, and/or systems level.

1.0 Readiness for Practicum

Essential Components	**A) Empowerment:** Is aware of social, political, economic and cultural factors that impact individuals, institutions and systems, in addition to other factors that may lead them to seek intervention	**B) System Change:** Understands the differences between individual and institutional level interventions and system's level change
Behavioral Anchor	Articulates social, political, economic or cultural factors that may impact on human development and functioning	Articulates role of therapist as change agent in areas that extend beyond of direct patient contact

Advocacy

2.0 Readiness for Internship

Essential Components	**A) Empowerment:** Uses awareness of the social, political, economic or cultural factors that may impact human development in the context of service provision	**B) System Change:** Promotes change to enhance the functioning of individuals
Behavioral Anchor	Identifies specific barriers to client improvement, e.g., lack of access to resources;	Identifies target issues/agencies most relevant to specific issues; Formulates and engages in plan for action;
	Assists client in the development of self-advocacy plans	Demonstrates understanding of appropriate boundaries and times to advocate on behalf of client

Advocacy

3.0 Readiness for Entry to Practice

Essential Components	**A) Empowerment:** Intervenes with client to promote action on factors impacting development and functioning	**B) System Change:** Promotes change at the level of institutions, community, or society
Behavioral Anchor	Promotes client self-advocacy; Assesses implementation and outcome of client's selfadvocacy plans	Develops alliance with relevant individuals and groups; Engages with groups with differing viewpoints around the issue to promote change

Advocacy

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Empowerment:** Consistently and appropriately intervenes with clients to promote action on factors impacting development and functioning	**B) System Change:** Promotes significant change at the level of institutions, community, or society
Behavioral Anchor	Consistently promotes client self-advocacy; Consistently assesses implementation and outcome of client's self advocacy plans	Consistently develops alliances with relevant individuals and groups; Skillfully engages with groups with differing viewpoints around complex issues to promote change

Advocacy

5.0 Readiness for Lifetime learning/Master Clinician

Essential Components	**A) Empowerment:**	**B) System Change:**
	Masterfully intervenes with clients to promote action on factors impacting development and functioning	Promotes significant change at the level of multiple institutions and society.
Behavioral Anchor	Masterfully promotes client self-advocacy; Assesses implementation and outcome of client's self-advocacy plans	Skillfully develops and maintains alliance with relevant individuals and groups; Skillfully engages with groups with differing viewpoints around complex issues and promote effectual change

II. Officer Development

Development of identity as a Naval officer and military psychologist.

1.0 Readiness for Practicum

Essential Components	**A) Military Knowledge and Officership:** Is aware of military regulations governing officers and able to access them when needed. Has basic awareness of the components of military bearing.	**B) Career Commitment as a Navy psychologist:** Is aware of career opportunities in Navy psychology.
Behavioral Anchor	Articulates commitment to being a Naval officer. Discusses regulations pertaining to role as an officer.	Begins to seek out more information and make connections in the military psychology community.

2.0 Readiness for Internship

Essential Components	**A) Military Knowledge and Officership:** Shows beginning awareness of military regulations related to mental health of service members. Has awareness of the components of military bearing.	**B) Career Commitment as a Navy psychologist:** Has growing awareness of specific career opportunities in Navy psychology. Explores organizations for military psychologists.
Behavioral Anchor	Articulates ways in which military regulations and ethical obligations as a psychologist can conflict. Consistently shows military bearing.	Discusses types of embedded experiences for Navy psychologists. Begins to participate in military psychology organizations.

3.0 Readiness for Entry into Practice

Essential Components	**A) Military Knowledge and Officership:** Is well aware of military regulations related to mental health of service members. Has developed identity as Naval officer.	**B) Career Commitment as a Navy psychologist:** Has in-depth awareness of specific career opportunities in Navy psychology. Is an active part of the military psychology community.
Behavioral Anchor	Discusses military regulations related to mental health, including in special populations. Conceptualizes and resolves ethical conflicts and dilemmas particular to military psychology. Consistently shows strong military bearing.	Identifies specific career goals in Navy psychology. Actively participates in military psychology organizational experiences.

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Military Knowledge and Officership:** Has high level of awareness regarding military regulations related to mental health of service members. Has well developed identity as Naval officer.	**B) Career Commitment as a Navy psychologist:** Has high level of awareness of specific career opportunities in Navy psychology. Is well-integrated into the military psychology community.
Behavioral Anchor	Knowledgeably and articulately discusses military regulations related to mental health, including in special populations. Independently conceptualizes and resolves ethical conflicts and dilemmas particular to military psychology. Consistently shows excellent military bearing.	Actively pursues specific career goals in Navy psychology. Seeks out advanced training opportunities. Actively participates in military psychology organizational experiences.

5.0 Readiness for Lifetime learning/Master Clinician

Essential Components	**A) Military Knowledge and Officership:** Sets an example in terms of knowledge and officership.	**B) Career Commitment as a Navy psychologist:** Has attained expertise in a specific career field in Navy psychology. Is recognized as a leader in the Navy psychology community.
Behavioral Anchor	Is recognized as a leader in terms of knowledge of military psychology and strengths as an officer. Is sought after to provide trainings and mentorship to others.	Has attained a leadership position in a specific clinical or operational unit. Has a leadership role in an organization specific to military psychology.

III. Professionalism

Professional values and ethics as evidenced in behavior and comportment that reflects the values and ethics of psychology, integrity, and responsibility.

1.0 Readiness for Practicum

Essential Components	**A.) IntegrityHonesty, personal**	**B.) Deportment:**	**C.) Accountability:**	**D.) Concern for the welfare of others:**	**E.) Professional Identity:**

	responsibility and adherence to professional values: Understanding of professional values; Honesty, personal responsibility	Understands how to conduct oneself in a professional manner	Accountable and reliable	Awareness of the need to uphold and protect the welfare of others	Beginning understanding of self as professional, "thinking like a psychologist"

Behavioral Anchors	Demonstrates honesty, even in difficult situations; Takes responsibility for own actions; Displays basic understanding of core professional values; Demonstrates ethical behavior and basic knowledge of APA ethical principles and code of conduct: see below: Foundational Competency:	Demonstrates appropriate personal hygiene and attire; Distinguishes between appropriate and inappropriate language and demeanor in professional contexts	Turns in assignments in accordance with established deadlines; Demonstrates personal organizational skills; Plans and organizes own workload; Aware of and follows policies and procedures of institution	Displays initiative to help others; Articulates importance of concepts of confidentiality, privacy, informed consent; Demonstrates compassion	Has membership in professional organizations; Demonstrates knowledge of the program and profession (training model, core competencies); Demonstrates knowledge about practicing within one's competence; Understands that knowledge goes beyond formal training

	Ethical-legal standards-policy				

Professionalism

2.0 Readiness for Internship

Essential Components	**A.) IntegrityHonesty, 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	**B.) Deportment:** Professionally appropriate communication and physical conduct, including attire, across different settings	**C.) Accountability:** Consistently reliable; Consistently accepts responsibility for own actions	**D.) Concern for the welfare of others:** Consistently acts to understand and safeguard the welfare of others	**E.) Professional Identity:** Emerging professional identity as psychologist; Uses resources (e. g., Supervision, literature) for professional development

Behavioral Anchors	Demonstrates knowledge of professional values; Demonstrates adherence to professional values; Identifies situations that challenge professional values, and seeks	Demonstrates awareness of the impact behavior has on client, public and profession; Utilizes appropriate language and demeanor in	Completes required case documentation promptly and accurately; Accepts responsibility for meeting deadlines;	Regularly demonstrates compassion; Displays respect in interpersonal interactions with others including those from divergent perspectives or backgrounds;	Attends colloquial, workshops, conferences; Consults literature relevant to client care
	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	professional communication; Demonstrates appropriate physical conduct, including attire, consistent with context	Available when "on-call"; Acknowledges errors; Utilizes supervision to strengthen the effectiveness of practice	Determines when response to client needs takes precedence over personal needs	

Professionalism

3.0 Readiness for Entry to Practice

Essential Components	**A.) IntegrityHonesty, personal responsibility and adherence to professional values:** Continually monitors and independently resolves situations that challenge professional values and integrity	**B.) Deportment:** Consistently conducts self in a professional manner across all settings and situations	**C.)Accountability:** Independently accepts personal responsibility across settings and contexts	**D.) Concern for the welfare of others:** Independently acts to safeguard the welfare of others	**E.) Professional Identity:** Consolidation of professional identity as a psychologist; knowledgeable about issues central to the field; evidence of integration of science and practice

Behavioral Anchors	Articulates professional values; Takes independent action to correct situations that are in conflict with professional values	Verbal and nonverbal communications are appropriate to the professional context including in challenging interactions	Works to fulfill client-provider contracts; Enhances productivity; Holds self accountable for and submits to external review of quality service provision	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	Keeps up with advances in profession; Contributes to the development and enhancement of the profession and colleagues; Demonstrates integration of science in professional practice

Essential Components	**A.) IntegrityHonesty, personal responsibility and adherence to professional values:**	**B.) Deportment:** Is viewed by colleagues and superiors as highly professional	**C.) Accountability:** Recognized as role model for peers for independently and	**D.) Concern for the welfare of others:** Is forward thinking with regard to problems that may impinge	**E.) Professional Identity:** Exhibits full consolidation of identity as a psychologist; Broadly knowledgeable about issues central to the field; Consistently integrates science and practice

			consistently demonstrating	on the welfare of others;	

Professionalism

4.0 Readiness for Fully Autonomous Practice

	Habitually monitors and resolves situations that challenge professional values and integrity		personal responsibility	keeps the ability to safeguard the welfare of others as the foremost priority	
Behavioral Anchors	Confidently articulates professional values; Consistently takes independent action to correct situations that are in conflict with professional values	Effectively communicates both verbally and nonverbally in the professional setting	Works to fulfill all professional responsibilities across settings; Demonstrates evidence of independent monitoring and optimizing of productivity; Consistently holds self accountable for and seeks external review of quality service provision	Communications and actions consistently convey sensitivity to individual experience and needs while retaining professional demeanor and deportment; Without fail is respectful of the beliefs and values of colleagues even when inconsistent with personal beliefs and values; Actively seeks to benefit the welfare of others, especially those in need	Spontaneously exhibits evidence of knowledge regarding recent advances in profession; Actively contributes to the development and enhancement of the profession and colleagues; Demonstrates habitual integration of science in professional practice

Professionalism

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A.) IntegrityHonesty, personal responsibility and adherence to professional values:** Sets the example in the community for integrity, honesty and professional responsibility	**B.) Deportment:** Is viewed by colleagues and peers as a mentor in the community regarding professional deportment and is sought after for mentorship	**C.) Accountability:** Recognized as a role model for advanced practitioners in terms of taking personal responsibility across all professional settings	**D.) Concern for the welfare of others:** Serves as a role model in terms safeguarding the welfare of others	**E.) Professional Identity:** Epitomizes identity as a psychologist; Uncommonly knowledgeable about issues central to the field; Sets the professional standard for the integration of science and practice

Behavioral Anchors	Articulates professional values in a manner that sets a standard for the psychological community. Takes independent action to correct situations that are in conflict with professional values and does so in a manner that is worthy of emulation by professional peers.	Verbal and nonverbal communication in professional settings sets a standard for peer emulation	Fulfills all professional responsibilities across settings in an exemplary manner; Functions as a mentor to advanced practitioners in regards to optimizing productivity; Invariably holds self accountable for and seeks external review of quality service provision	Communications and actions convey sensitivity to individual experience in an uncommonly sensitive and skillful manner while retaining the highest degree of professional demeanor and deportment; Epitomizes respectful acceptance of the beliefs and values of colleagues, especially when inconsistent with personal beliefs and values;	Exhibits rarely surpassed knowledge regarding recent advances in profession; Is a recognized leader in the development and enhancement of the profession Exhibits exemplary integration of science in professional practice

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

				Serves as a role model to the profession in seeking to benefit the welfare of others, especially those in need	

Practice conducted with personal and professional self-awareness and reflection; with awareness of competencies; with appropriate self-care.

1.0 Readiness for Practicum

Essential Components	**A) Reflective Practice:** Basic mindfulness and selfawareness; basic reflectivity regarding professional practice (reflection-on-action)	**B.) Self-Assessment:** Knowledge of core competencies; emerging selfassessment re: competencies	**C.) Self -Care (attention to personal health and well-being to assure effective professional functioning):** Understanding of the importance of selfcare in effective practice; knowledge of self-care method; attention to self-care
Behavioral Anchor	Displays: Problem solving skills Critical thinking; Organized reasoning; Intellectual curiosity and flexibility Demonstrates openness to:	Demonstrates awareness of clinical competencies for professional training; Develops initial competency goals for early training (with input from faculty)	Demonstrates basic awareness and attention to self-care

	Considering own personal concerns & issues Recognizing impact of self on others Articulating attitudes, values, and beliefs, toward diverse others Self-identifying multiple individual and cultural identities Systematically reviewing own professional performance with supervisors/teachers		

Reflective Practice/Self-Assessment/Self-Care

2.0 Readiness for Internship

Essential Components	**A) Reflective Practice:** Broadened self-awareness; selfmonitoring; reflectivity regarding professional practice (reflection-on-action); use of resources to enhance reflectivity; elements of reflection-in-action	**B.) Self-Assessment:** Broadly accurate selfassessment of competence; consistent monitoring and evaluation of practice activities	**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	Articulates attitudes, values and beliefs towards diverse others; Recognizes impact of self on others; Self-identifies multiple individual and cultural identities;	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;	Worked with supervisor to monitor issues related to self-care; Takes action recommended by supervisor for self-care to ensure effective training
	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	Identifies learning objectives for overall training plan; Systematically and effectively reviews own professional performance via videotape or other technology	

Reflective Practice/Self-Assessment/Self-Care

3.0 Readiness for Entry to Practice

Essential Components	**A) Reflective Practice:** Use thoughtful reflection in professional practice (reflection-in-action), reflection acted upon; self used as a therapeutic tool	**B.) Self-Assessment:** Accurate self-assessment of competence in all competency domains; integration of selfassessment in practice	**C.) Self -Care (attention to personal health and well-being to assure effective professional functioning)** Self-monitoring of issues related to self-care and prompt interventions when disruptions occur
Behavioral Anchor	Demonstrates frequent congruence between own and others' assessment and seeks to resolve incongruities; Models self-care;	Accurately identifies level of competence across all competency domains; Accurately assesses own strengths and weaknesses and	Anticipates and self-identifies disruptions in functioning and intervenes at an early stage/with minimal support from supervisors; Models self-care
	Monitors and evaluates attitudes and values and beliefs towards individuals who differ from self; 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	seeks to prevent or ameliorate impact on professional functioning; Recognizes when new/improved competencies are required for effective practice	

Reflective Practice/Self-Assessment/Self-Care

4.0 Readiness for Fully Autonomous Practice

Essential Components	**A) Reflective Practice:** Consistently exhibits reflectivity in context of professional practice (reflection-in-action); habitually acts upon reflections and uses self as a therapeutic tool	**B.) Self-Assessment:** Exhibits particularly accurate self-assessment of competence in all competency domains; habitually integrates selfassessment in practice	**C.) Self -Care (attention to personal health and well-being to assure effective professional functioning)** Reliably self-monitors issues related to selfcare and executes prompt interventions when disruptions occur
Behavioral Anchor	Demonstrates accurate congruence between own and others' assessment and seeks to resolve incongruities; Habitually monitors and evaluates attitudes and values	Identifies level of competence across all competency domains with a high degree of accuracy; Systematically reviews own professional performance via videotape or other technology	Consistently anticipates and self-identifies disruptions in functioning and intervenes at an early stage without needing support from colleagues; Effectively models self-care
	and beliefs towards individuals who differ from self; Highly effective in monitoring professional performance in action as situation requires; Habitually recognizes and addresses own problems leading to minimal interference with competent professional functioning	and changes behavior based on this self-monitoring; Anticipates disruptions in functioning due to personal issues with minimum support from supervisors.	

Reflective Practice/Self-Assessment/Self-Care

5.0 Readiness for Lifelong Learning/Master Clinician

Essential Components	**A) Reflective Practice:** Exhibits exemplary reflectivity in context of professional practice (reflection-in-action); acts upon reflections and uses self as a therapeutic tool in an uncommonly skillful manner	**B.) Self-Assessment:** Exhibits self-assessment of competence in all competency domains at an accuracy level found only among the most advanced practitioners; habitually and efficiently integrates self-assessment in practice	**C.) Self -Care (attention to personal health and well-being to assure effective professional functioning):** Serves as a role model for effective selfmonitoring of issues related to self-care and executes prompt and effective interventions when disruptions occur

Behavioral Anchor	Demonstrates particularly accurate congruence between own and others' assessment and habitually seeks to resolve incongruities; Monitors and evaluates attitudes and values and beliefs towards diverse others in an highly skillful manner; Models the highest standard in effectively monitoring professional performance in action as situation requires; Habitually and quickly recognizes and addresses own problems leading to minimal interference with competent professional functioning	Identifies level of competence across all competency domains with an exceptionally high degree of accuracy; Systematically and routinely reviews own professional performance via videotape or other technology; clearly recognizes when deficits in knowledge, skills, and abilities are sub par, and changes behavior based on selfmonitoring through appropriate collegial consultation “heading off” any disruptions in clinical effectiveness	Exhibits an exemplary ability to anticipate and self-identify disruptions in functioning and models highly effective interventions at an early stage. Effectively models self-care and facilitates such among colleagues

APPENDIX B

Supervision Contracts and Ratings

SUPERVISION CONTRACT:
PSYCHOLOGY POSTDOCTORAL FELLOWSHIP
Rotation : Post-Traumatic Stress Disorder and Depression

This is an agreement between LT _____, hereafter referred to as fellow, and Dr. _____, hereafter referred to as primary supervisor. This agreement was signed on _____after a period of observation by the primary supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent and advanced practice in working with individuals who have varying degrees of depressive and trauma symptoms. Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings within which depression, PTSD, and other associated disorders may be encountered.

Training will occur in the outpatient mental health clinic, Building 3, 3rd deck of NMCP. This clinic services active duty service members from the Navy, Army, Marines, Coast Guard, and Air Force. Over the course of a 6-month training experience, the fellow will conduct diagnostic interviews and provide treatment to patients with depressive disorders and trauma-related disorders and, for the sake of breath of training, will also see some patients with other psychiatric disorders. Fellow will conduct initial diagnostic interviews to establish diagnoses and to determine symptom severity, suicide/homicide risk factors, and substance use issues. Fellow will also develop appropriate treatment plans and provide evidence based treatments such as Cognitive Behavioral Therapy, Prolonged Exposure, or Cognitive Processing Therapy. The work day starts at 0730 and extends beyond 1630 Monday through Friday, though Fellow will spend Wednesdays on minor rotations. The fellow will not see patients after 1600 during the week, on weekends, or any time when there is no credentialed psychologist in the clinic.

The primary supervisor who assumes clinical responsibility for the patients seen by the fellow, will provide a minimum of one hour of scheduled, face to face, individual supervision each week, in addition to supervision provided as needed on an ad hoc basis over the course of the training period. Additionally, the supervisor will provide at least one hour of scheduled group supervision each week. The supervisor and the fellow will submit by close of business each Friday a weekly supervision form (see Program Manual).

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

- A sharing of supervisors' background and clinical competencies germane to the provision of mental health services to persons with depressive and trauma-related disorders.
- Specific instructions regarding clinic procedures and clinical documentation guidelines that are peculiar to the outpatient clinic.
- A training/supervision experience composed of, but not limited to the following elements:
    - Opportunity to observe supervisor and/or other staff members conducting diagnostic interviews and/or treatment.
    - Opportunity to review patient notes containing initial evaluations, progress notes, and termination notes.
    - Observation by supervisor of diagnostic interviews and treatment services provided by the fellow in sufficient numbers to support satisfactory completion of this training objective.

    - Review of and feedback regarding written diagnostic reports, treatment plans, and progress notes entered into the electronic medical record
- Respect for biopsychosocial factors, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:

- **The availability of the primary 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 primary supervisor is away from the work setting.

Supervisor may expect the following from the fellow:

- Adherence to outpatient clinic policies, and ethical and legal codes.
- Use of standard outpatient clinical evaluation and report templates.
- Completion of all clinical documentation on the day of service delivery.
- Prompt notification of high risk status in any patient.
- Provision of audio or video taped sessions when requested by the supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of the primary supervisor.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the primary supervisor bears liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- Ongoing documentation of relevant information and activities during this training period into the fellow's portfolio.
- **An understanding that the primary supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.**

DEPRESSION AND TRAUMA TRAINING SPECIFIC OBJECTIVES:

Global Objective: The fellow will demonstrate ability to diagnose and render effective interventions to service members, retirees, and family members with depressive and trauma-related disorders.

Specific Objective 1: Conduct an effective and accurate diagnostic interview for patients presenting with depressive and/or trauma-related symptoms. This interview should be supplemented psycho-diagnostic testing when appropriate.

Specific Objective 2: Provide evidence-based care for depressive and trauma-related disorders in accordance with DOD/VA Clinical Practice Guidelines. Specifically, the fellow will provide Cognitive Behavior Therapy or Acceptance and Commitment Therapy for patients with depressive disorders and Cognitive Processing Therapy or Prolonged Exposure Therapy to patients with trauma-related disorders. The fellow will augment these therapies or select other therapies as needed to meet the needs of specific patients.

Specific Objective 3: The fellow will determine when patients with depressive or trauma disorders can no longer continue to function in their current military capacity and will determine appropriate placement on Limited Duty or on a Medical Board; the fellow will also determine when patients are ready to resume full military duties.

Individual rotation goals are set via discussion between the fellow and the rotation supervisor. These goals may focus on acquisition of specific skills or on the development of more fluid abilities, such as improving ability to manage one's own responses in a therapy session. These goals are not evaluated formally but should be discussed frequently during supervision.

Rotation Goals (please specify at least two goals):

_____

_____

_____

Signatures at the initiation of this Supervision Contract

_____ _____

Primary Supervisor Psychology Postdoctoral Fellow

The fellow's overall performance in this training objective is judged to be:

____Unacceptable for demonstrating advanced practice
____Marginally Acceptable for demonstrating advanced practice
____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective [Date: _____]

_____ _____

Primary Supervisor Psychology Postdoctoral Fellow

SUPERVISION CONTRACT:
PSYCHOLOGY POSTDOCTORAL FELLOWSHIP **Rotation:**
General Outpatient

This is an agreement between LT _____, hereafter referred to as fellow, and Dr. _____, hereafter referred to as primary supervisor. This agreement was signed on _____after a period of observation by the primary supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent and advanced practice in working with military service members. Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings.

Training will occur in the outpatient mental health clinic, Building 3, 3rd deck of NMCP. This clinic services active duty service members from the Navy, Army, Marines, Coast Guard, and Air Force. Over the course of a 5-month training experience, the fellow will conduct diagnostic interviews and provide treatment to patients with a wide range of presenting problems. An emphasis on this rotation will be the ability to determine service members' ability to continue to work in their current military setting, as well as the correct pathway for members who are unable to do so. To this end, fellows will perform Access to Care assessments for service members who have urgent safety and/or occupational issues that require a sooner appointment than usual care. These assessments frequently require contact with patients' supervisors, medical providers, and/or commanding officers to determine the optimal resolution for the patient. Fellows will gain experience with documentation for Limited Duty placement, medical boards, and administrative separations. Fellows will also see other intake assessments appropriate for their training needs. Fellows will maintain a caseload of patients with diverse presenting problems with an emphasis on providing evidence-based therapies. The work day starts at 0730 and extends beyond 1630 Monday through Friday, though the Fellow will spend at 1east 10 Wednesdays on the Embedded minor rotation. The fellow will not see patients after 1600 during the week, on weekends, or any time when there is no credentialed psychologist in the clinic.

The primary supervisor who assumes clinical responsibility for the patients seen by the fellow, will provide a minimum of one hour of scheduled, face to face, individual supervision each week, in addition to supervision provided as needed on an ad hoc basis over the course of the training period. Additionally, the supervisor will provide at least one hour of scheduled group supervision each week. The supervisor and the fellow will submit by close of business each Friday a weekly supervision form (see Program Manual).

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

- A sharing of supervisors' background and clinical competencies germane to the provision of mental health services to persons with depressive and trauma-related disorders.
- Specific instructions regarding clinic procedures and clinical documentation guidelines that are peculiar to the outpatient clinic.
- A training/supervision experience composed of, but not limited to the following elements:
    - Opportunity to observe supervisor and/or other staff members conducting diagnostic interviews and/or treatment.

  - Opportunity to review patient notes containing initial evaluations, progress notes, and termination notes.
  - Observation by supervisor of diagnostic interviews and treatment services provided by the fellow in sufficient numbers to support satisfactory completion of this training objective.
  - Review of and feedback regarding written diagnostic reports, treatment plans, and progress notes entered into the electronic medical record
- Respect for biopsychosocial factors, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
- **The availability of the primary 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 primary supervisor is away from the work setting.

Supervisor may expect the following from the fellow:

- Adherence to outpatient clinic policies, and ethical and legal codes.
- Use of standard outpatient clinical evaluation and report templates.
- Completion of all clinical documentation on the day of service delivery.
- Prompt notification of high risk status in any patient.
- Provision of audio or video taped sessions when requested by the supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of the primary supervisor.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the primary supervisor bears liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- Ongoing documentation of relevant information and activities during this training period into the fellow's portfolio.
- **An understanding that the primary supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.**

GENERAL OUTPATIENT TRAINING SPECIFIC OBJECTIVES:

Global Objective: The fellow will demonstrate ability to conduct diagnostic assessments of military service members with a wide range of presenting problems and occupational issues.

Specific Objective 1: Conduct an effective and accurate diagnostic interview for patients presenting with mental health symptoms that are impacting military readiness. This interview should be supplemented psychodiagnostic testing when appropriate.

Specific Objective 2: Serve as a consultant to military commands regarding the appropriate military status of patients referred for urgent evaluations.

Specific Objective 3: Demonstrate ability to complete required documentation reflecting a change in the service member's fitness or suitability for military duty.

Global Objective: The fellow will demonstrate ability to provide mental health treatment to service members with a wide range of presenting problems.

Specific Objective 1: Independently generate treatment plans that are sensitive to military resources and demands and to biopsychosocial variables.

Specific Objective 1: Provide evidence-based interventions consistent with the patient's needs and fellow theoretical orientation.

Individual rotation goals are set via discussion between the fellow and the rotation supervisor. These goals may focus on acquisition of specific skills or on the development of more fluid abilities, such as improving ability to manage one's own responses in a therapy session. These goals are not evaluated formally but should be discussed frequently during supervision.

Rotation Goals (please specify at least two goals):

_____

_____

_____

Signatures at the initiation of this Supervision Contract

_____ _____

Primary Supervisor Psychology Postdoctoral Fellow

The fellow's overall performance in this training objective is judged to be:

____Unacceptable for demonstrating advanced practice
____Marginally Acceptable for demonstrating advanced practice
____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective [Date: _____]

_____ _____

Primary Supervisor Psychology Postdoctoral Fellow

SUPERVISION CONTRACT: POSTDOCTORAL FELLOWSHIP
PSYCHOLOGY DEPARTMENT
NAVAL MEDICAL CENTER PORTSMOUTH, VA

Rotation: Health Psychology

This is an agreement between _____, hereafter referred to as fellow, and _____and _____ (if applicable), hereafter referred to as supervisor(s). This agreement was signed on _____after a period of observation by the supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent practice working with individuals with chronic pain. Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings within which chronic pain and related conditions may be encountered.

Training will occur in the Outpatient Mental Health Clinic and in a medical specialty clinic to be determined by the fellow, the supervisor, and specialty clinic staff. Over the course of a 6-month training experience, the fellow will spend approximately three days a week working with a health psychologist in the Outpatient Mental Health Clinic seeing chronic pain patients and approximately two days a week in the specialty clinic.

Chronic Pain Component

In addition to chronic pain and related medical conditions, patients may present with mood disorders, somatoform disorders, psychological factors affecting medical conditions, as well as personality disorders. Referrals may be from orthopedic providers, the NMCP Pain Clinic, Neurology, and other medical and surgical clinics at this facility and branch clinics. Patients may be active duty service members, retired military, and/or adult family members. The fellow will interview new patients, conceptualize and develop treatment plans, and provide empirically validated treatment for chronic pain conditions. These treatments may be delivered on an individual or group basis. The fellow may consult with the referring provider and with the commands of active duty service members. The fellow will not see patients after 1600 during the week, on weekends, or any time when there is no credentialed psychologist in the clinic.

Specialty Clinic Component

Specific duties at the specialty care clinic will be determined in collaboration between the specialty care supervisor, the clinic medical provider, and the trainee and will reflect the needs of the population being served. In general, the post-doc should expect to perform brief, problem-focused assessments and therapy, conduct group interventions relevant to the population, act as a consultant in a multidisciplinary setting, and potentially see patients for longer-term therapy as needed.

The supervisor(s), who assumes clinical responsibility for the patients seen by the fellow, will provide a minimum of two hours of scheduled face to face supervision per week and will be available for supervision and consultation as needed on an ad hoc basis over the course of the rotation. The scheduled supervision will be from 0730 to 0800 and 1530 to 1600. The supervisor(s) will provide input on the fellow's weekly supervision forms (see Program Manual). At the end of the rotation the supervisor(s) will complete a summative assessment and will provide oral feedback to the fellow.

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

- A sharing of supervisors' background and clinical competencies germane to the provision of mental health services to persons with medical and pain conditions.
- Specific instructions regarding the health psychology pain intake process, initial evaluation, and treatment modalities.
- A training/supervision experience composed of, but not limited to the following elements:
    - Direct observation of the supervisor during 2 or more evaluations during the first weeks of the rotation and discussion of relevant treatment protocols.
    - Direct observation by the supervisor of the fellow's initial diagnostic interviews.
    - Observation by the supervisor of recorded intakes and therapy sessions.

 Respect for biopsychosocial factors, and power differences within the supervisor- supervisee-patient triad.

- A relationship characterized by:
- Open communication and two-way feedback.
- The expectation that the fellow will voice disagreements and differences of opinion.
- Attention to personal factors, such as values, beliefs, biases, and predisposition.
- **The availability of the primary supervisor for any and all emergency situations above and beyond scheduled supervision times.**
- Timely completion of supervision-related administrative procedures.

The supervisor(s) may expect from LT _____the following:

- Adherence to the psychology code of ethics, military legal codes, and clinic policies.
- Use of standard clinical evaluation and report templates as indicated.
- Completion of all clinical documentation on the day of service delivery (progress notes) or within 72 hours (assessment reports).
- Prompt notification of high risk status in any patient.
- Provision of audio or video taped sessions when requested by the supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of the 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 fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- Ongoing documentation of relevant information and activities during this training period into the fellow's w o r k s a m p l e s portfolio.
- An understanding that the primary supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.

Health Psychology Training Objectives:

Global Objective 1: The fellow will demonstrate ability to diagnose and render effective psychosocial interventions to service members, family members, and retirees with chronic pain conditions.

Specific Objective 1: Perform assessments of patients with chronic pain, including identification of psychosocial factors impacting the patient's pain condition. Accurately diagnose somatoform disorders when appropriate.

Specific Objective 2: Demonstrate ability to diagnose Somatic Symptom and Related Disorders when appropriate.

Specific Objective 3: Provide time-limited cognitive behavioral therapy and acceptance and commitment therapy interventions for chronic pain.

Global Objective 2: The fellow will demonstrate advanced psychological skills in general health psychology, including a variety of presenting problems (sleep, TBI, , other areas of fellow interest).

Specific Objective 1: Provide assessments of patients with a variety of health psychology presenting problems.

Specific Objective 2: Provide focused health psychology groups and individual therapy.

Specific Objective 3: Provide consultation to other members of a multidisciplinary team.

Fellow's Rotation Goals (please specify at least two goals):

_____

_____

_____

Signatures at the initiation of this Supervision Contract

_____ _____

Primary Supervisor Additional Supervisor

_____

Post-Doctoral Fellow

End of Rotation Evaluation

In light of the above constellation of supervisor-rated competency levels, the fellow's overall performance in this training objective is judged to be:

_____Unacceptable for demonstrating advance practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective Date: _____

_____ _____
Primary Supervisor Additional Supervisor

_____
Post-Doctoral Fellow

SUPERVISION CONTRACT:
PSYCHOLOGY POSTDOCTORAL FELLOWSHIP NAVAL MEDICAL CENTER PORTSMOUTH, VA

Rotation: Child and Family Intervention

This is an agreement between _____ hereafter referred to as Fellow, and Dr. _____, hereafter referred to as the Supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent practice in working with individuals who have Family Issues as part of their presenting problems. Supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings within which Family Issues as part of their presenting problems.

Training will occur over the course of 6 months in the Outpatient Child Mental Health Clinic, bldg. 3, 3rd deck of NMCP. This clinic services children of active duty and retired service members from the Navy, Army, Marines, Coast Guard, and Air Force. The rotation emphasizes responding to the unique challenges military families face while utilizing evidence-based therapeutic interventions for various treatment needs. The rotation prepares the fellow to provide assessment, intervention and consultation with families of active duty service members. Fellows will develop skills in the areas of diagnostic interviewing, treatment planning, and providing appropriate interventions and case management. Fellows will provide individual, group, and family therapy and consult with medical providers, school personnel, and commands, as necessary. Fellows will also develop competence in conducting comprehensive psychological evaluation/assessment for the purposes of diagnostic clarification and treatment planning. Fellows will receive exposure to Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for disruptive behavior and attachment problems in preschool-age children. Groups provided in this clinic include psychoeducation and skill building to address anger management, AD/HD, anxiety, parenting, mood, and self-harm. Other opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate. The fellow will primarily be supervised by a child psychologist but will also have the opportunity to work with psychiatrists (attending and residents) and licensed clinical social work staff. The work day starts at 0730 and may extend beyond 1600 on each Wednesday of the training period. The fellow will not see patients after 1600 during the week, on weekends, or any time when there is no credentialed psychologist in the office.

Supervisor, who assumes clinical responsibility for the patients seen by the fellow for the Family Issues rotation, will provide a minimum of two hours of scheduled, face to face individual supervision each week. Additional individual and/or group supervision will be provided in sufficient amounts to ensure sound guidance of the fellow's clinical work and adherence to APA's supervision requirements. Supervisor, with the input from the fellow, will submit on the Monday following each training week a weekly supervision form see below corresponding to the preceding week. At the end of this training experience, the supervisor will provide a final summary rating.

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

- A sharing of all supervisors' backgrounds and clinical competencies germane to the provision of mental health services to persons with family issues.

NAVAL MEDICAL CENTER PORTSMOUTH POSTDOCTORAL FELLOWSHIP TRAINING PROGRAM MANUAL

- Specific instructions regarding outpatient clinical documentation guidelines that are particular to this facility.
- A training/supervision experience composed of, but not limited to the following elements:
  - Opportunity to observe attending supervisor and/or other staff conducting diagnostic interviews/treatment.
  - Opportunity to gain further family support systems knowledge as outlined in the objectives below.
  - Opportunity to review patient notes containing initial evaluations, progress notes, and termination notes.
  - Observation by supervisory of diagnostic interviews and treatment services provided by the fellow in sufficient number s to support satisfactory completion of this rotation.
  - Review of and feedback regarding written diagnostic reports, treatment plans, and progress note entered into the electronic medical record.

- Respect for biopsychosocial factors and power differences within the supervisor-supervisee patient triad.
- A relationship characterized by:
  - Open communication and two-way feedback.
  - The expectation that the fellow will voice disagreements and differences of opinion.
  - Attention to personal factors, such as values, beliefs, biases, and predisposition.
  - The availability of a 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.

Supervisor may expect from fellow the following:

- Adherence to outpatient clinic, ethical and legal codes and policies
- Use of standard outpatient clinical evaluation, report and/or note templates as indicated. Completion of all clinical documentation in a timely manner Prompt notification of high risk status in any new patient.
- Provision of audio or video taped sessions when requested by a supervisor.
- Openness and receptivity to feedback.

- Adherence to the requirement that all patients be provided with name and contact information of supervisors responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisors bear liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- An understanding that a supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.

CHILD AND FAMILY INTERVENTION TRAINING SPECIFIC OBJECTIVES:

Global Objective: The fellow will demonstrate ability to diagnose and render effective interventions to children and adolescents, parents, and family units placed under stress by operational requirements of active duty/retired service members at a competency level that exceeds readiness for entry to practice.

Specific Objective 1: Knowledge and utilization of family and child behavioral health resources such as FFSC, FAP, FOCUS, EFMP, Tricare, MWR, EDIS, chaplain, , recreation, religious organizations, school child study teams, juvenile justice, and support groups (in-person and online).

Specific Objective 2: Articulate common family and/or child psychology presenting problems, complications associated with military (including active reserve) lifestyle/ service cycles, and/or service related trauma/loss. Demonstrate the ability to identify and address these issues in clinical practice commensurate with the developmental level specified below.

Specific Objective 3: Demonstrate familiarity with military family and child psychology triage, case management, assessment, and intervention. This includes awareness and utilization of child/family behavioral health resources, discernment/prioritization of bio-psychosocial issues that need intervention, formulation/implementation of individual/family/group interventions, and use/interpretation of psychological assessment measures.

Specific Objective 4: Demonstrate competence at functioning within a multidisciplinary treatment approach. This involves consulting with other personnel involved in the child's care, including pediatricians, specialty medical providers (e.g., nutritionists, occupational therapists), psychiatrists, teachers, school staff, and other involved mental health providers (e.g., inpatient/residential facility staff, in-home and ABA therapists). The fellow should demonstrate recognition of the value of coordinated care and the ability to work collaboratively with other professionals, including in cases in which differences of opinion/competing interests are present. The fellow will independently communicate with other providers and will elicit and provide feedback to inform treatment planning.

Individual rotation goals are set via discussion between the fellow and the rotation supervisor. These goals may focus on acquisition of specific skills or on the development of more fluid abilities, such as improving ability to manage one’s own responses in a therapy session. These goals are not evaluated formally but should be discussed frequently during supervision.

Rotation Goals (please specify at least two goals):

_____
_____
_____

Signatures at the initiation of this Supervision Contract

_____ _____
Primary Supervisor Psychology Postdoctoral Fellow

End of Rotation Evaluation

In light of the above constellation of supervisor-rated competency levels, the fellow's overall performance in this training objective is judged to be:

_____Unacceptable for demonstrating advance practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective Date: _____

_____ _____
Primary Supervisor Psychology Postdoctoral Fellow

INPATIENT/ACUTE CARE SUPERVISION CONTRACT:
PSYCHOLOGY POSTDOCTORAL FELLOWSHIP
PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Training Domain: Inpatient/Acute Care

This is an agreement between _____, hereafter referred to as fellow, _____;hereafter referred to as primary supervisor, _____; hereafter referred to as ward attending psychiatrist supervisor; and _____, hereafter referred to as ER/CL (Emergency Room/Consult Liaison) attending psychiatrist supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent and advanced practice in working with individuals who have acute mental health crises requiring inpatient or intensive outpatient psychiatric management. Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings within which acute psychiatric crises may be encountered.

Training will occur on psychiatric unit 5E/5F of Building 2 of NMCP, as well as NMCP ER over the course of 4 weeks. Unit 5E/5F provides intensive inpatient psychiatric treatment for both active duty and family members, including dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus another mental health condition), Under the direction of _____ (ward attending psychiatrist supervisor), the fellow will attend and participate in morning rounds, interview new patients, develop and monitor treatment/discharge plans, provide individual therapy/crisis intervention, and conduct psychological testing as needed. The fellow will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated mental health services. The fellow will also consult with family members and the commands of active duty service members to make decisions regarding military disposition. Under the direction of _____(ER/CL attending psychiatrist supervisor) the fellow will also spend time in the Emergency Room performing acute assessments of patients presenting in crisis. The fellow may also provide consultation/liaison services to medical wards. Start and end times of the work day will be determined at the discretion of the attending supervisors.

_____ (primary supervisor) will provide a minimum of one hour, scheduled, face to face individual supervision each week. This supervision will be held at a mutually convenient time. Additionally, supervision will be provided as needed on an ad hoc basis over the course of the training period. The fellow will additionally receive a minimum of 3 hours of supervision from the attending psychiatrist supervisor(s), i.e., _____each week. This supervision may be provided in either an individual or group format (i.e., along with psychiatric residents and/or other trainees). The fellow with the input from supervisors, will submit on the Monday following each training week a weekly supervision form for each supervisor (Enclosure A) corresponding to the preceding week. At the end of this training experience both the fellow and the primary supervisor (in consultation with the adjunct supervisor) will complete competency ratings, as outlined below, and the supervisor will provide a final summary rating as per the scale provided below.

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

- A sharing of all supervisors' backgrounds and clinical competencies germane to the provision of mental health services to persons with severe psychiatric disorders.
- Specific instructions regarding psychiatric inpatient ward and emergency room operating procedures and clinical documentation guidelines that are peculiar to the inpatient facility.
- A training/supervision experience composed of, but not limited to the following elements:
  - Opportunity to observe attending psychiatrists, psychiatric residents and/or other inpatient staff members conducting initial interviews and/or interviews during rounds.
  - Opportunity to review inpatient charts containing intake evaluations, progress notes, and discharge plans.
  - Opportunity to observe inpatient psychiatry residents conduct emergency psychiatric evaluations.
- **S**upervisor's evaluations of fellow are based on: ▪ Observation of initial interviews.
  - Review of initial interview reports, treatment plans, and progress notes entered into the medical record.
  - Observation of case presentations made during inpatient rounds ▪ Feedback from the other supervisors.
- Respect for biopsychosocial factors, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
  - Open communication and two-way feedback.
  - The expectation that the fellow will voice disagreements and differences of opinion.
  - Attention to personal factors, such as values, beliefs, biases, and predisposition.
- **The availability of a 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.

Supervisors may expect the following from the fellow:

- Adherence to inpatient ward, Emergency Room, and medical wards ethical and legal codes and policies.
- Use of standard setting-specific evaluation and report templates as indicated.
- Completion of all clinical documentation on the day of service delivery.
- Prompt notification of high-risk status in any new patient.
- Provision of audio or video taped sessions when requested by a supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisors responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisors bear liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- Ongoing documentation of relevant information and activities during this training period into the fellow's portfolio.
- **An understanding that a supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.**

INPATIENT/ACUTE CARE TRAINING SPECIFIC OBJETIVES

Performance Objectives

By the end of the specified training period the fellow will demonstrate the ability to accurately assess, diagnose, and admit persons presenting with acute crisis and/or severe psychiatric illness. The fellow will demonstrate a collaborative approach in developing and applying appropriate treatment recommendations within the context of a multidisciplinary team. Performance by the end of this training period will be reflective of advanced practice, as defined in the program's training manual.

Individual rotation goals are set via discussion between the fellow and the rotation supervisor. These goals may focus on acquisition of specific skills or on the development of more fluid abilities, such as improving ability to manage one's own responses in a therapy session. These goals are not evaluated formally but should be discussed frequently during supervision.

Rotation Goals (please specify at least two goals):

_____

_____

_____

Signatures at the initiation of this Supervision Contract

_____ _____

Primary Supervisor Psychology Postdoctoral Fellow

_____ _____

Ward Attending Psychiatrist Supervisor ER/CL Attending Psychiatrist Supervisor

End of Rotation Evaluation

The fellow's overall performance in this training objective is judged to be:

_____Unacceptable for demonstrating advance practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective [Date: _____]

_____ _____
Primary Supervisor Psychology Postdoctoral Fellow

_____ _____
Ward Attending Psychiatrist Supervisor ER/CL Attending Psychiatrist Supervisor

SUPERVISION CONTRACT: PSYCHOLOGY POSTDOCTORAL FELLOWSHIP
PSYCHOLOGY DEPARTMENT, NAVAL MEDICAL CENTER PORTSMOUTH, VA

Training Minor Rotation: Embedded Psychology

This is an agreement between LT _____, hereafter referred to as Fellow, and Dr. _____, hereafter referred to as the Supervisor. This agreement was signed on _____ after a period of observation by the supervisor. The purpose of supervision is to prepare the fellow, as a clinical psychologist, for independent and advanced practice in working in an embedded setting (e.g., aircraft carrier, submarine squadron, etc.). Though a primary goal of this training is preparation for service within the United States Navy, supervision and clinical experiences will be sufficiently broad to enhance professional competencies in a wide range of clinical settings.

Training will occur one day per week in the embedded setting: _____. Over the course of at least a 10-week period, the fellow will conduct diagnostic interviews and provide treatment to service members in the embedded setting. Under the direction of Supervisor, the fellow will determine when service members are no longer fit or suitable to remain in the embedded setting and will make appropriate placement determinations. The fellow will also have the opportunity to participate with the supervisor in activities such as briefing command leadership about specific mental healthrelated situations and consulting with other medical professionals involved in the service members' care.

Supervisor, who assumes clinical responsibility for the patients seen by the fellow for the Embedded Psychology rotation, will provide a minimum of one hour of scheduled, face to face individual supervision each week. Additional individual and/or group supervision will be provided in sufficient amounts to ensure sound guidance of the fellow's clinical work and adherence to APA's supervision requirements. Fellow, with the input from the supervisor, will submit on the Monday following each training week a weekly supervision form see below corresponding to the preceding week. At the end of this training experience the supervisor will rate the fellow's performance as either unacceptable, marginally acceptable, or acceptable for demonstrating advanced practice.

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

- A sharing of all supervisors' backgrounds and clinical competencies germane to the provision of mental health services in an embedded setting.
- Specific instructions regarding outpatient clinical documentation guidelines that are peculiar to embedded psychology.
- A training/supervision experience composed of, but not limited to the following elements:
    - Opportunity to observe attending supervisor and/or other staff conducting diagnostic interviews/treatment.

- Opportunity to gain further embedded psychology knowledge as outlined in the objectives below.
- Opportunity to review patient notes containing initial evaluations, progress notes, and termination notes.

- Observation by supervisor of diagnostic interviews and treatment services provided by the fellow in sufficient number s to support satisfactory completion of this rotation.
- Review of and feedback regarding written diagnostic reports, treatment plans, and progress note entered into the electronic medical record.

- Respect for biopsychosocial factorsand power differences within the supervisor-supervisee patient triad.
- A relationship characterized by:
  - Open communication and two-way feedback.
  - The expectation that the fellow will voice disagreements and differences of opinion.
  - Attention to personal factors, such as values, beliefs, biases, and predisposition.
  - The availability of a 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.

Supervisors may expect from fellow the following:

- Adherence to carrier, ethical and legal codes and policies.
- Use of standard carrier evaluation, report and/or note templates as indicated.
- Completion of all clinical documentation in a timely manner.
- Prompt notification of high risk status in any new patient.
- Provision of audio taped sessions when requested by a supervisor.
- Openness and receptivity to feedback.
- Adherence to the requirement that all patients be provided with name and contact information of supervisors responsible for their case.
- Proper preparation for all supervision sessions and prompt attendance.
- An understanding that the supervisors bear liability in supervision and thus it is essential that the fellow share complete information regarding patients and abide by the supervisor's final decisions, as the welfare of the patient is tantamount.
- Ongoing documentation of relevant information and activities during this training period into the fellow's portfolio.

- An understanding that a supervisor must be notified promptly in the case of an emergency and independent of scheduled supervision times, whenever patient safety is in jeopardy.

EMBEDDED PSYCHOLOGY TRAINING SPECIFIC OBJECTIVES:

Global Objective: The fellow will demonstrate ability to diagnose and render effective interventions to service members in an embedded setting that exceeds readiness for entry to practice.

Specific Objective 1: Demonstrate utilization of embedded behavioral health resources, such as psychiatric technicians, ships' medical officers and deployment resiliency counselors.

Specific Objective 2: Determine when service members are no longer fit or suitable to remain in the embedded setting and provide appropriate recommendations for a period of Limited Duty, immediate referral to a medical board, or administrative separation. Effectively consult with and provide feedback to the service member's chain of command when making this determination.

Specific Objective 3: Perform brief, focused assessments of service members on both a scheduled and walk-in basis.

Specific Objective 4: Provide time-limited, problem-focused psychotherapy to service members in either a group or individual setting in the embedded setting.

Individual rotation goals are set via discussion between the fellow and the rotation supervisor. These goals may focus on acquisition of specific skills or on the development of more fluid abilities, such as improving ability to manage one's own responses in a therapy session. These goals are not evaluated formally but should be discussed frequently during supervision.

Rotation Goals (please specify at least two goals):

_____
_
_____
_
_____
_

Signatures at the initiation of this Supervision Contract

_____ _____
Primary Supervisor Psychology Postdoctoral Fellow

End of Rotation Evaluation

The fellow's overall performance in this training objective is judged to be:
_____Unacceptable for demonstrating advance practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice

Signatures at the completion of this training objective [Date: _____]

_____ _____
Primary Supervisor Psychology Postdoctoral Fellow

APPENDIX C

Mid-Year and End-of-Year
Competency Assessment Rating Scale

Mid-Year and End-of-Year Competency Assessment Rating Scale

Naval Medical Center Portsmouth
Psychology Postdoctoral Fellowship Training Program
Competency Assessment Rating Scale

Fellow: _____ Raters: _____

Consensus Rating: includes input from primary supervisor, training director, and another training faculty member.

_____MID-YEAR _____END-OF-YEAR

This form is intended to be used in conjunction with the Fellowship Training Program's Competency Benchmarks document to assign competency ratings for each of 7 Foundational and 8 Functional competency domains at the end of the rotation noted above. Ratings are provided by consensus by the fellow's Competency Committee, as discussed in the program manual. 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 Fellowship
1.75 Approaches or meets some criteria for Readiness for Fellowship
2.00 Meets criteria for Readiness for Fellowship
2.25 Mildly exceeds some criteria for Readiness for Fellowship
2.50 Mid-way between Readiness for Fellowship 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

Expected* and Minimally Acceptable Competency Ratings

Mid-Year	End-of-Year
3.5 (3.0, 3.25)**	4.0 (3.5, 3.75)**

* Ratings are based on consensus judgments made by the fellow's competency committee ** The first number in parentheses specifies the minimally acceptable rating for an individual competency domain. The second number specifies the lowest acceptable average rating across all advanced competencies and focused, program specific competencies.

Advanced Competencies

I. <u>Integration of Science and Practice:</u> Scientific Knowledge, Research Evaluation, Assessment, Intervention, Supervision

A. Scientific Knowledge. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form items 9 & 15.

Essential Components:

____A: Scientific Mindedness

____B: Knowledge

____C: Scientific Foundations

_____ Final Rating

B. Research Evaluation. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form item 13; Case Presentation Rating Form item 9 & 14.

Essential Components:

____A: Scientific Approach to Knowledge Generation

____B: Application of Scientific Method to Practice

_____ Final Rating

C. Assessment. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form items 1-8, 10-14; 17-20; Case Presentation Rating Forms items 4 & 8; Clinical Supervision Rating Form item 4.

Essential Components:

____A: Measurement and Psychometrics

____B: Evaluation Methods

____C: Application of Methods

____D: Diagnosis

____E: Conceptualization and Recommendations

____F: Communication of Findings

_____ Final Rating

D. Intervention. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form items 8, 15, 23- 28) ; Case Presentation Rating Form items 5; Patient Perception Rating Form item 9; Clinical Supervision Rating Form items 6&7.

Essential Components:

____A: Knowledge of Interventions

____B: Intervention Planning

____C: Skills

____D: Intervention Implementation

____E: Progress Evaluation

_____ Final Rating

E. Supervision. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Clinical Supervision Rating Form items 1-10.

Essential Components:

_____A: Expectation and Roles

_____B: Process and Procedures

_____C: Skills Development

_____D: Awareness of factors affecting quality

_____E: Participation in Supervision Process

_____F: Ethical and Legal Issues

_____Final Rating

F. Teaching. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Case Presentation Rating Form item 16.

Essential Components:

_____A: Knowledge

_____B: Skills

_____ Final Rating

_____Averaged Total of Final Ratings for Integration of Science and Practice

II. Individual and Cultural Diversity

Assessment Methods: Direct supervisor observation and discussion during supervision sessions and participation in Lunch and Learn Discussion ; Review of fellow's Self-Study; Work Samples Rating Form items 9, 16, 24, & 29; Case Presentation Rating Forms items 6 & 11; Patient Perception Rating Form item 4; Clinical Supervision Rating Form items 5 & 10.

Essential Components:

_____A: Self as shaped by individual and cultural diversity

_____B: Others as shaped by individual and cultural diversity

_____C: Interactions of self and others as shaped by individual and cultural diversity

____D: Applications based on individual and cultural context

_____ Final Rating for Individual and Cultural Diversity

III. Ethical Legal Standards and Policy

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Participation in Lunch and Learn Discussions; Review of fellow's Self-Study; Case Presentation Rating Form item 10; Patient Perception Rating Form item 7.

Essential Components:

____A: Knowledge of ethical, legal and professional standards and guidelines

____B: Awareness and Application of Ethical Decision Making

____C: Ethical Conduct

_____ Final Rating for Ethical Legal Standards and Policy

Focused, Program Specific Competencies

I. Consultation and Advocacy: Interdisciplinary Systems, Consultation, Relationships, Advocacy

A. Interdisciplinary Systems. Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's self- study; Case Presentation Rating Form item 7; Interdisciplinary Team Member Survey items 4-6.

Essential Components:

____A: Knowledge of the shared and distinctive contributions of other professions

____B: Functioning in multidisciplinary and interdisciplinary contexts

____C: Understands how participation in interdisciplinary collaboration/consultation enhances outcomes

____D: Respectful and productive relationships with individuals from other professions

_____ Final Rating

B. Consultation. Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form item 8; Case Presentation Rating Form item 13& 17; Consultation Services Survey items 3-5;

Essential Components:

____A: Role of Consultant

____B: Addressing Referral Question

____C: Communication of Findings

____D: Application of Methods

_____ Final Rating

C. Relationships. Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form items 22 & 26; Patient Perception Rating Form item 8; Support Staff Survey item 1; Clinical Supervision Rating Form item 1.

Essential Components:

____A: Interpersonal Relationships

____B: Affective Skills

____C: Expressive Skills

_____ Final Rating

D. Advocacy Methods Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Case Presentation Rating Form item 14.

Essential Components:

____A: Empowerment

____B: System Change

_____ Final Rating

_____Averaged Total of Final Rating Consultation and Advocacy

II. Officer Development
Assessment methods : Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Support Staff Survey items 3&4.

Essential Components:

____A: Military Knowledge and Officership

____B: Career commitment as a Navy Psychologist

_____ Final Rating Officer Development

III. Professionalism
Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Work Samples Rating Form items 21 & 25; Patient Perception Rating Form items 1-3; Interdisciplinary Team Member Survey items 1-3; Consultation Services Survey items 1-3; Support Staff Survey item 2.

Essential Components:

____A: Integrity, Honesty, personal responsibility and adherence to professional values

____B: Deportment

____C: Accountability

____D: Concern for the welfare of others

____E: Professional Identity

_____ Final Rating Professionalism

IV. Reflective Practice/Self-Assessment/Self-Care
Methods Assessment methods: Direct supervisor observation and discussion during supervision sessions; Review of fellow's Self-Study; Case Presentation Rating Form item 12.

Essential Components:

____A: Reflective Practice

____B: Self-Assessment

____C: Self-Care (attention to personal health and well-being to assure effective professional functioning

_____ Final Rating Reflective Practice/Self-Assessment/Self-Care

Summary of Ratings:

Advanced Competencies	Focused, Program Specific Competencies
_____Integration of Science and Practice	____Consultation and Advocacy
_____Individual and Cultural Diversity	____Officer Development
_____Ethical Legal Standards and Policy	____Professionalism
	____Reflective Practice/Self-Assessment/Self-Care

____Average rating of all Advanced Competencies
____Average rating of all Focused, Program Specific Competencies

Clinical Supervisor Summary Evaluations Per Training Rotation:

Major Rotation *(Circle one):* Mood Disorders/PTSD, Health, Child/Family
- ___Either not completed at time of rating or training has yet to be initiated
- ___Completed with the rating assigned indicated below
  - ____Unacceptable for demonstrating advanced practice
  - ____Marginally Acceptable for demonstrating advanced practice
  - ____Acceptable for demonstrating advanced practice

Major Rotation: General Outpatient
- ___ Either not completed at time of rating or training has yet to be initiated
- ___Completed with the rating assigned indicated below:
  - ____Unacceptable for demonstrating advanced practice
  - ____Marginally Acceptable for demonstrating advanced practice
  - ____Acceptable for demonstrating advanced practice
  - ____ Not Applicable

Inpatient/Acute Care—Minor Rotation:

___Either not completed at time of rating or training has yet to be initiated
___Completed with the rating assigned indicated below:
_____Unacceptable for demonstrating advanced practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice

Embedded Psychology—Minor Rotation:
___Either not completed at time of rating or training has yet to be initiated
___Completed with the rating assigned indicated below:
_____Unacceptable for demonstrating advanced practice
_____Marginally Acceptable for demonstrating advanced practice
_____Acceptable for demonstrating advanced practice
_____ Not applicable

Summative Findings

For Mid-Year Assessment:

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

For End-of-Year Assessment:

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

Comments: _____

_____

_____

_____

_____

Date: _____

_____ _____

Fellow

_____

_____

Competency Committee Members

Fellow Statement: I do/do not agree with the above ratings.
Comments: _____
_____
_____
_____

APPENDIX D

Competency Self-Assessment

Naval Medical Center Portsmouth Clinical Psychology Postdoctoral Fellowship

Competency Self-Assessment

Name: _____

Please rate yourself, using the following scale and the Competency Benchmarks, for each competency domains in the tables provided below.

Dates of Completion: Entry To Training Program: _____
Mid-Year Evaluation _____
End of Year Evaluation _____

Competency Rating Scale

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

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Integration of Science and Practice

Individual and Cultural Diversity

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Ethical Legal Standards and Policy

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Consultation and Advocacy

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Officer Development

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Professionalism

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

Reflective Practice/Self-Assessment/Self-Care

	Entry To Training Program	Mid-Year Evaluation	End-of-Year Evaluation
Rating			
Basis for Rating			

APPENDIX E

Clinical Work Samples Rating Form

05

Naval Medical Center Portsmouth Fellowship Training Program

Clinical Work Samples Rating Form

Fellow: _____ **Rater:** _____ **Date**: _____

For each rating requested below use the following numerical scale. The referent for the "Good" classification is the average psychologist who is ready to enter practice. By the end of the training year, fellows would be expected to consistently obtain ratings of "4" and "5" on this form. 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

Written Diagnostic Interview Report

Case # _____

Informed consent documented 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.

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 Fellow'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 Fellow 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 Fellow 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 Fellow 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 indicated. 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 indicated. 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, if indicated, 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 a necessary 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.) Diagnosis:

_____ 5 Fellow'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. All relevant diagnoses are included on all axes.

_____ 4 Fellow'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. All relevant diagnoses are included on all axes.

_____ 3 Report reflects an understanding of diagnostic nomenclature and the DSM-V non-axial system. Information needed to rule-in and rule-out diagnoses is adequate. All relevant diagnoses are included.

_____ 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. One or more relevant diagnoses may be absent.

_____ 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.

8.) Recommendations and Disposition

_____ 5 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the Adult Outpatient Mental Health Clinic, if applicable. The recommendations reflect solid knowledge of evidence based practice and specifies goals of treatment, patient strengths and limitations, treatment modality and expected length of treatment, if applicable. Presence or absence of occupational limitations is clearly noted.

_____ 4 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the Adult Outpatient Mental Health Clinic, if applicable. Recommendations reflect knowledge of evidence based practice and specifies goals of treatment and treatment modality, if applicable. Presence or absence of occupational limitations is noted.

_____ 3 Fellow formulates recommendations that include appropriate treatment goals and treatment modality. Recommendations may lack specificity or may fail to take into account available community/military resources. Presence or absence of occupational limitations is implied.

_____ 2 Fellow is unable to identify intervention strategies that are appropriate for the case and needs supervision to make appropriate recommendations to the patient and command. Fitness for duty may be absent or inaccurate.

_____ 1 Fellow does not provide recommendations for psychological treatment or available resources/future contacts. Or fellow creates recommendations that are clearly inappropriate.

9.) Sensitivity to Cultural 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 fellow 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 Fellow 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 biopsychosocial issues in need of attention in this report are noted by rater.

10.) Overall Written Communication Skills

_____ 5 Report is clear and thorough, follows a coherent outline, and is an effective summary of major relevant issues. Recommendations are useful and clearly address referral questions.

_____ 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. 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 at least 3 consecutive progress notes from the same patient. In instances of differing quality of documentation, the most recent work sample receive the heaviest weighting.

Case # _____

11.) 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.

12.) Objective: Observed Features

_____ 5 Fellow documents objective status of the patient in a manner that reflects an uncommonly thorough understanding of features of the mental status examination and in a manner that reflects 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 exceptionally high.

_____ 4 Fellow documents objective status of the patient in a manner that reflects a solid understanding of 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 an understanding of the mental status examination. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Fellow's notes contain fragments of a mental status examination in reporting objective features of the patient's status in each session. 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.

13.) Objective: Measurements

_____ 5 Progress notes include data from one or more objective tests/instruments designed to evaluate session by session patient status/outcomes. 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. Notes do 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.

14.) Assessment of Suicide and Homicide Risks:

_____ 5 For at risk patients, 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. A fully adequate crisis plan is documented in each progress note. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 For at risk patients, 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. 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 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 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. Applicable risk and protective factors are not addressed, and a necessary 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 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.

15.) Treatment Plan

_____ 5 Progress notes include a treatment plan that is consistent with patient's needs, military demands, and ethical practice guidelines. The plan reflects solid knowledge of evidence based practice and specifies goals of treatment, treatment modality and expected length of treatment. The treatment plan indicates the patient's progress toward goals. Indications for changes in the treatment plan are clear in the body of progress notes. Consultations with other members of the treatment team are referenced, as are efforts to advocate on behalf of the patient, if applicable.

_____ 4 Progress notes include a treatment plan that is consistent with patient's needs, military demands, and ethical practice guidelines. The plan reflects awareness of evidence based practice and specifies goals of treatment, treatment modality and expected length of treatment. The treatment plan indicates the patient's progress toward goals. Indications for changes in the treatment plan are reported. Some consultations with other members of the treatment team are referenced.

_____ 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.

_____ 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.

_____ 1 Notes provide no treatment plan or one that appears to be either completely generic or inappropriate.

16.) Sensitivity to Cultural Issues:

_____ 5 The progress notes reflect exceptionally strong awareness of cultural issues relevant to the particular patient, including how these issues may influence the patient's current symptoms and response to treatment.

_____ 4 The progress notes reflect awareness of cultural issues relevant to the particular patient, including how these issues may influence the patient's current symptoms and response to treatment.

_____ 3 The progress notes reflect basic knowledge re cultural issues relevant to the particular patient. The fellow documents when these issues are addressed.

_____ 2 The progress notes acknowledge cultural issues relevant to the patient but do not comment meaningfully on them.

_____ 1 The notes reflect a fundamental lack of understanding of cultural issues.

_____ N/A- No relevant cultural issues in need of attention are noted by rater.

Evaluation of Recorded Diagnostic Interview

Fellow 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.) Diagnostic Assessment:

_____ 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 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 fellow'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.

_____ 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.

_____ 3 Collects adequate historic and relevant information. May fail to ask important follow up questions at times during the interview.

_____ 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.) Assessment of Suicide and Homicide Risks:

_____ 5 Fellow assesses suicide and homicide risks at a level appropriate to the risk factors of the patient. Interview style reflects strong knowledge of research literature on risk and protective factors for suicide and homicide. If indicated, fellow discusses a well thoughtout crisis plan with the patient in a clear and appropriate manner.

_____ 4 Fellow assesses suicide and homicide risks thoroughly. Interview style reflects good working knowledge of risk factors literature. If indicated, fellow discusses a crisis plan with the patient in a clear and appropriate manner.

_____ 3 Fellow assesses suicide and homicide risks adequately. Interview style reflects rudimentary knowledge of research on risk factors. If indicated, fellow discusses a basic crisis plan with the patient.

_____ 2 Fellow 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 Fellow fails to recognize safety issues and does not ask questions about suicidal/homicidal ideations, intent or plan.

20.) Professionalism:

_____ 5 Fellow conducts the interview with a remarkable level of professionalism. Fellow expertly maintains the structure of the interview while remaining sensitive to the individual experience and needs of the patient. Fellow clearly demonstrates respect for the beliefs and values of the patient.

_____ 4 Fellow conducts the interview with a high level of professionalism. Fellow is able to maintain the structure of the interview while remaining sensitive to the individual experience and needs of the patient. Fellow demonstrates respect for the beliefs and values of the patient.

_____ 3 Fellow conducts the interview with an adequate level of professionalism, although may appear hesitant or unsure at times. In general the interview is organized but flexible to accommodate the needs of the patient. The fellow is not disrespectful to the beliefs and values of the patient.

_____ 2 The interview may not be well-organized or may follow a rigid set of questions without taking into account the need for flexibility. The fellow may have lapses in professional demeanor, such as unwarranted self-disclosure or use of language inappropriate to the patient or situation.

_____ 1 Fellow fails to maintain a professional demeanor.

21.) Relationship Skills:

_____ 5 Fellow establishes a strong therapeutic alliance with the patient. Fellow provides warmth and empathy and is unusually sensitive to the patient's emotional state. The fellow communicates exceptionally clearly and effectively with the patient. The fellow is able to resolve difficult situations, if present, in a manner that minimizes the potential for conflict.

_____ 4 Fellow establishes a therapeutic alliance with the patient. Fellow provides warmth and empathy and is sensitive to the patient's emotional state. The fellow communicates clearly and effectively with the patient. The fellow is able to resolve difficult situations, if present, in a manner that minimizes the potential for conflict.

_____ 3 Fellow is able to establish a positive working relationship with the patient. The fellow is usually able to convey warmth, empathy, and sensitivity to the patient's emotional state. Information is conveyed adequately. If difficult situations arise, the fellow may at first appear anxious or defensive but is able to resolve them satisfactorily.

_____ 2 The fellow struggles to establish a therapeutic alliance. The fellow does not appear sensitive to the patient's emotional state and may seem dismissive or disinterested. If difficult situations arise, the fellow has difficulty resolving them.

_____ 1 The fellow alienates the patient and shows a marked deficiency in relationship skills.

22.) Awareness of Biopsychosocial Issues:

_____ 5 Fellow takes the initiative to discuss individual differences 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 assessment. If the patient is from a distinct minority group, it is apparent that
the fellow has an understanding of how that culture may influence mental health issues.

_____ 4 Fellow take 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 Fellow shows adequate ability to discuss differences that exist between self and patient in terms of race, ethnicity, culture and other individual difference variables. Fellow does not initiate discussion with patient about these differences unless brought up by patient. Fellow is open to patient discussing experiences related to cultural background but does not specifically ask about these experiences.

_____ 2 Fellow may acknowledge some individual cultural identity variables but appears uncomfortable discussing them. Fellow misses clear opportunities to inquire about the impact of the patient's cultural background on current or past experiences.

_____ 1 The fellow demonstrates a fundamental lack of understanding of cultural issues, such as labeling behaviors appropriate in a specific minority culture as mental health symptoms or dismissing patient's concerns about individual difference variables.

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

Evaluation of Recorded Therapy Session

23.) Professionalism:

_____ 5 Fellow conducts the session with a remarkable level of professionalism. Fellow clearly demonstrates respect for the beliefs and values of the patient.

_____ 4 Fellow conducts the interview with a high level of professionalism. Fellow demonstrates respect for the beliefs and values of the patient.

_____ 3 Fellow conducts the session with an adequate level of professionalism, although may appear hesitant or unsure at times. The fellow is not disrespectful to the beliefs and values of the patient.

_____ 2 The fellow may have lapses in professional demeanor, such as unwarranted selfdisclosure or use of language inappropriate to the patient or situation.

_____ 1 Fellow fails to maintain a professional demeanor.

24.) Relationship skills:

_____ 5 Fellow establishes a strong therapeutic alliance with the patient. Fellow provides warmth and empathy and is unusually sensitive to the patient's emotional state. The fellow communicates exceptionally clearly and effectively with the patient. The fellow acknowledges and works skillfully to resolve any therapeutic impasses.

_____ 4 Fellow establishes a therapeutic alliance with the patient. Fellow provides warmth and empathy and is sensitive to the patient's emotional state. The fellow communicates clearly and effectively with the patient. The fellow acknowledges and works to resolve any therapeutic impasses.

_____ 3 Fellow is able to establish a positive working relationship with the patient. The fellow is usually able to convey warmth, empathy, and sensitivity to the patient's emotional state. Information is conveyed adequately. If a therapeutic impasse arises, the fellow may at first appear anxious or defensive but works to resolve it.

_____ 2 The fellow struggles to establish a therapeutic alliance. The fellow does not appear sensitive to the patient's emotional state and may seem dismissive or disinterested. The fellow has difficulty resolving any therapeutic impasses that arise.

_____ 1 The fellow alienates the patient and shows a marked deficiency in relationship skills.

25.) Intervention (CPT or PE):

_____ 5 Fellow follows the protocol closely and skillfully. Fellow appears exceptionally comfortable and familiar with the protocol and does not appear to be reading from a script. Fellow adapts explanations to suit the patient's level of education and psychological-mindedness. Fellow redirects the patient to stay on protocol in a way that allows patient to feel supported regarding current stressors or distress.

_____ 4 Fellow follows the protocol closely. Fellow appears comfortable and familiar with the protocol and does not appear to be reading from a script. Fellow adapts explanations to suit the patient's level of education and psychological-mindedness.

_____ 3 Fellow follows the protocol closely with only minor deviations. Fellow appears comfortable with the protocol. Fellow checks with patient to ensure understanding and provides further explanation if needed.

_____ 2 Fellow has difficulty staying on track with the protocol. Fellow may have difficulty allotting time to session components and fails to finish the session. Or fellow 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.

26.) Intervention (CBT, IPT, DBT, ACT, Short-Term Psychodynamic, 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. Fellow tracks or reflects patient statements in session with a high level of skill, and maintains patient's motivation to work. Fellow 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. Fellow tracks or reflects patient statements in session, and maintains patient's motivation to work. Fellow 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. Fellow tracks or reflects patient statements in session most of the time, but at times seems to follow own agenda. Fellow 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. Fellow sometimes has difficulty targeting the interventions to patient's level of understanding and motivation. Fellow may follow own agenda in the session but responds to patient's needs when patient explicitly voices them. Alternatively, fellow's agenda may be unclear, and the session may lack structure.

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

29.) Awareness of Biopsychosocial Issues:

_____ 5 Fellow takes the initiative to discuss individual differences 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 fellow has an understanding of how that culture may influence mental health issues.

_____ 4 Fellow take 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 Fellow shows adequate ability to discuss differences that exist between self and patient in terms of race, ethnicity, culture and other individual difference variables. Fellow does not initiate discussion with patient about these differences unless brought up by patient. Fellow is open to patient discussing experiences related to cultural background but does not specifically ask about these experiences.

_____ 2 Fellow may acknowledge some individual cultural identity variables but appears uncomfortable discussing them. Fellow misses clear opportunities to inquire about the impact of the patient's cultural background on current or past experiences.

_____ 1 The fellow demonstrates a fundamental lack of understanding of cultural issues, such as prescribing interventions contrary to a cultural norm or dismissing patient's concerns about individual difference variables.

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

Comments: _____

_____

APPENDIX F

360-Degree-like Customer Perception Surveys

Naval Medical Center Portsmouth Postdoctoral Fellowship Program

Patient Perception Survey

Date: _____ Administrative Assistant: _____ Fellow: _____

Patient Initials: _____ Patient's Age _____Sex: _____Ethnicity: _____

Duty Status (e.g., Active Duty, retiree, family member): _____Rank: ____Service: _____

Rotation (circle one): Depression PTSD Inpatient Chronic Pain Family TBI Embedded

Evaluation Sequence (circle one): Midyear End of year

I am Mr. /Ms. _____]. I am the Administrative Assistant for the Psychology Training Programs. I would like to ask you about your impressions of _____(the fellow) 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 _____(fellow) 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 fellow) made it clear to you that he/she is in a training program and is under _____(fellow'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/her self 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:

_____
_____
_____
_____

Naval Medical Center Portsmouth Postdoctoral Fellowship

Interdisciplinary Team Member Survey

Date: _____ Administrative Assistant: _____ Fellow: _____

Evaluation: ___Mid-Year ____End of Training

Initials of Team Member: _____ Profession: _____

I would like to ask you a few questions about one of our fellows, _____, 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 fellow 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 fellow) 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 postdoctoral fellow is and his/her role on the treatment team.

_____3.) _____conducted him/her self 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.

_____7.) _____displayed proper military bearing as a member 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 Postdoctoral Fellowship

Consultation Services Survey—Administrative Assistant Version

Date: _____ Administrative Assistant: _____ Fellow: _____

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

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

Evaluation: ___ Mid-Year ____ End of Training 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 Postdoctoral Fellowship Program. I would like to ask you about your impressions of the consultation services you recently received from one of our postdoctoral fellows, _____(fellow's name) regarding _____(patient's name). Your responses will help evaluate _____'s (fellow's name) performance in our program. Please be candid and truthful in your answers. Your responses will be shared with _____(the fellow) 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 fellow) made it clear to you that he/she is in a training program and is under _____'s (supervisor's name) supervision.

_____2.) _____conducted him/her self 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 _____.

_____ 6.) _____showed proper military bearing during this consultation.

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 Postdoctoral Fellowship

Support Staff
Survey
Date: _____ Administrative Assistant: _____Fellow: _____

Evaluation: __Mid-Year ____ End of Training Initials of support staff: _____

Support role (circle): Administrative support Psychiatric Technician Other: _____
I would like to ask you about your impressions of _____(fellow), who is currently working under _____(supervisor's name) supervision in our Postdoctoral Fellowship Training Program. Your responses will be shared with the fellow 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 fellow) 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 G

Case Presentation Rating Form

Naval Medical Center Portsmouth Fellowship Training Program

Case Presentation Rating Form

Fellow: _____ **Presentation Date**: _____ **Rater:** _____

For each rating requested below use the following numerical scale. The referent for the "Good" classification is the average psychologist who is ready to enter practice. By the end of the training year, fellows would be expected to consistently obtain ratings of "4" and "5" on this form. 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

1.) Case Material:

_____ 5 Fellow 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. Fellow was able to skillfully integrate historic information with current symptoms to clarify the clinical picture.

_____ 4 Fellow 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 Fellow 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 Fellow presented most relevant patient information, but left out some key clinical/historical facts or provided vague descriptions of such. There was little evidence of fellow's ability to integrate historic information with current symptoms.

_____ 1 Fellow 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 Fellow presented an unusually thorough suicide and (if applicable) homicide risk assessment. Presentation reflected strong knowledge of research literature on risk and protective factors for suicide and homicide. Fellow formulated an exceptional crisis plan, if indicated, and appropriate protective actions were taken if necessary.

_____ 4 Fellow presented a thorough suicide and (if applicable) homicide risk assessment. Presentation reflected good working knowledge of the risk factors literature. Fellow formulated an adequate crisis plan, if indicated, and appropriate protective actions were taken if necessary.

_____ 3 Fellow presented a basic suicide and (if applicable) homicide risk assessment. Presentation reflected rudimentary knowledge of research on risk factors. Fellow formulated a crisis plan, if needed, but it was in need of some refinement. Appropriate protective actions were taken if necessary.

_____ 2 Fellow assessed suicide and homicide risks superficially. May have failed to ask appropriate probing questions about risk factors or failed to assess protective factors. Fellow recognized the need for protective actions if indicated but may have failed to initiate the appropriate actions.

_____ 1 Fellow failed to recognize safety issues and did not assess suicidal/homicidal ideations, intent or plan.

3.) Diagnosis:

_____ 5 Fellow demonstrated an unusually thorough knowledge of mental health classification, including and relevant DSM-V diagnostic criteria, in supporting his/her diagnostic formulation. Fellow was unusually thorough in consideration of relevant patient data and accurately ruled out different diagnoses.

_____ 4 Fellow demonstrated thorough knowledge of mental health classification, including relevant DSM-V diagnostic criteria, in supporting his/her diagnostic formulation. Fellow considered relevant patient data to rule out different diagnoses.

_____ 3 Fellow 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 Fellow demonstrated only a rudimentary theoretical knowledge and understanding of basic diagnostic nomenclature and the DSM-V. Fellows omitted a number of patient facts needed to support his/her diagnostic formulation and/or to rule out different diagnoses.

_____ 1 Fellow demonstrated significant deficits in understanding of the mental health classification system and/or ability to use DSM-V criteria to develop a diagnostic conceptualization. Fellow gave the patient wrong diagnoses based on inaccurate interpretation of the DSM-V and/or inadequate data collection.

4.) Case Conceptualization:

_____ 5 Fellow 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 Fellow 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 Fellow 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 Fellow's case conceptualization reflected some limitations in theoretical understanding of the fellow's chosen orientation, and demonstrated a limited appreciation of the current literature regarding preferred orientation and evidence based treatments.

_____ 1 Fellow failed to reach a coherent case conceptualization from any orientation and was only able to report symptoms of the patient.

5.) Intervention:

_____ 5 Fellow provided a description of psychotherapy interventions that reflects a sophisticated understanding of psychological treatment. Outcome data were presented that strongly support fellow's description of therapeutic effectiveness and illustrate fellow's sophistication in understanding and using outcome measures.

_____ 4 Fellow provided a description of psychotherapy interventions that reflects a solid understanding of psychological treatment. Outcome data were presented that substantiate fellow's description of therapeutic effectiveness and illustrate fellow's awareness of the value of outcome measures.

_____ 3 Fellow provided a description of psychotherapy interventions that reflects a basic understanding of psychological treatment. Some outcome data were presented that support fellow's description of therapeutic effectiveness and illustrate fellow's basic awareness of the value of outcome measures.

_____ 2 Fellow 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 fellow's description of therapeutic progress.

_____ 1 Fellow 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.

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

_____ 5 Fellow demonstrated an unusually thorough understanding of how demands of military service and military life impact patient's functioning and treatment options. Fellow 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 Fellow demonstrated good understanding of how demands of military service and military life impact patient's functioning and treatment options. Fellow 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 Fellow 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 Fellow demonstrated limited awareness of important military issues and demands present in the case

_____ 1 Fellow demonstrated no awareness of important military issues and demands present in the case.

_____N/A

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

_____ 5 Fellow identified indications for consultation with other professional services and exhibited an unusually keen awareness of the value of interdisciplinary approaches to treatment.

_____ 4 Fellow 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 Fellow 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 Fellow 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 Fellow 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

8.) Recommendations:

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

_____ 4 Recommendations for a treatment case took into account various patient needs and military demands and took into consideration at least one cultural 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.

_____ 3 Recommendations for a treatment case took into account patient needs and one or more military demands and/or cultural 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.

_____ 2 Recommendations for a treatment case only superficially took into account patient's needs, military demands and/or cultural 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.

_____ 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).

9.) Scholarly Review of the Literature:

_____ 5 Fellow 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. Fellow used the knowledge gained to inform treatment or to positively impact assessment conclusions in an unusually skillful manner.

_____ 4 Fellow 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 Fellow 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 Fellow 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 Fellow did not conduct a literature review on a topic appropriate to the case or provided a very limited or inadequate one.

10.) Ethical and Legal Issues:

_____ 5 Fellow demonstrated unusually strong knowledge of the ethical principles and military laws and regulations pertinent to the case. Fellow demonstrated unusually strong judgment regarding actions to take to resolve or address ethical issues, if such were identified.

_____ 4 Fellow demonstrated full understanding of the ethical principles, and military laws and regulations pertinent to the case. Fellow was able to specify an appropriate means to resolve ethical issues in this case, if such were identified.

_____ 3 Fellow demonstrated some understanding of the ethical principles, and military laws and regulations pertinent to the case. If such were identified, fellow offered only a vague prescription for resolving ethical issues or indicated only the need to consult with a supervisor.

_____ 2 Fellow 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.

_____ 1 Fellow did not address ethical or legal concerns pertinent to this case.

11.) Biopsychosocial Issues:

_____ 5 Fellow 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. If the patient is from a distinct minority group, the fellow knowledgably discusses how that culture may influence mental health issues.

_____ 4 Fellow 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 biopsychosocial factors into consideration in case conceptualization/assessment and treatment planning.

_____ 3 Fellow 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. Fellow made some efforts to take biopsychosocial issues into consideration in case conceptualization/assessment and/or treatment planning.

_____ 2 Fellow demonstrated some recognition of individual differences between self and the patient but was unable to take biopsychosocial issues into full consideration when reaching case conceptualization/assessment and/or during treatment planning.

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

12.) Reflective Practice /Self-Care

_____ 5 Fellow insightfully reflects on strengths and limitations in terms of working with this particular patient. Fellow demonstrates strong awareness of factors such as countertransference and secondary traumatization. In difficult cases, fellow demonstrates a strong ability to self-monitor own reactions to patient and intervenes independently to care for own emotional needs in order to not impact patient care.

_____ 4 Fellow reflects on strengths and limitations in terms of working with this particular patient. Fellow demonstrates awareness of factors such as counter-transference and secondary traumatization. In difficult cases, fellow self-monitors own reactions to patient and proactively seeks guidance to care for own emotional needs in order to not impact patient care.

_____ 3 Fellow makes a good effort to reflect on strengths and limitations in terms of working with this particular patient. Fellow has a developing awareness of factors such as countertransference and secondary traumatization. Fellow may not initially be aware of own reactions to patient but accepts guidance and recommendations when raised by supervisor or peers.

_____ 2 Fellow has difficulty reflecting on strengths and limitations but shows an ability to seek supervision and guidance on issues regarding reflective practice. Fellow has deficits in knowledge of counter-transference and secondary traumatization but is open to discussion of the impact of own reactions on patient care.

_____ 1 Fellow has difficulty reflecting on strengths and limitations and is unwilling or unable to accept feedback. Major countertransference issues may be observed by others but denied or minimized by fellow. Fellow's response to patient appears to have significantly impacted patient care.

13.) Consultation Issues:

_____ 5 Fellow demonstrated a high degree of skill as per his/her descriptions of interactions with referral sources and/or military commands. Fellow 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 Fellow'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 Fellow'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 Fellow 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 Fellow 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 Fellow intervened with others on behalf of the patient to promote changes positively impacting the patient's functioning and/or well being. Fellow's actions fostered selfadvocacy on the part of the patient and also reflected fellow'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 Fellow 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 Fellow 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. Fellow demonstrated understanding of appropriate boundaries and times to advocate on behalf of patients.

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

_____ 1 Fellow did not address advocacy issues.

15) Teaching Ability:

_____ 5 Fellow's presentation suggested advanced ability to function in a teaching role; i.e., fellow communicated with a high degree of effectiveness, articulated concepts in an unusually clear manner, and addressed questions in an uncommonly effective manner.

_____ 4 Fellow's presentation suggested solid ability to function in a teaching role; i.e., fellow communicated effectively, articulated concepts in a clear manner, and was receptive to questions.

_____ 3 Fellow's presentation suggested basic ability to function in a teaching role; i.e., fellow communicated adequately, articulated concepts in an acceptable manner, and was able to provide reasonable answers to questions.

_____ 2 Fellow's presentation suggested limited ability to function in a teaching role; i.e., fellow 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.

16.) Peer Consultation:

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

_____ 4 Fellow's comments to peers following their presentations provided a clear indication of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her awareness of the differing role functions one assumes as a consultant.

_____ 3 Fellow's comments to peers following their presentations provided some indication of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her basic awareness of the differing role functions one assumes as a consultant.

_____ 2 Fellow's comments to peers following their presentations provided only limited indications of ability to suggest alternative approaches to conceptualizing case material. Fellow's verbal input reflected his/her limited awareness of the differing role functions one assumes as a consultant.

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

Comments: _____

_____

_____

_____

_____

_____

APPENDIX H

Supervision Skills Rating Form

Naval Medical Center Portsmouth Postdoctoral Fellowship Program

Supervision Skills Rating Form
Fellow name: _____
Time: (circle one) Mid-Year End-of-Year

Date: _____ Supervisee: _____ Rater: _____

Please indicate whether you are:

Supervisee: ____ Supervisor_____Training/Asst. Training Director: _____

Please rate the quality of clinical 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.) Supervisor provided a sense of acceptance and support.

_____2.) Supervisor established clear boundaries.

_____3). Supervisor provided both positive and corrective feedback to the supervisee.

_____4). Supervisor helped the supervisee conceptualize the case.

_____5.) Supervisor raised cultural issues relevant to the case.

_____6.) Supervisor offered practical and useful case-centered suggestions.

_____ 7.) Supervisor assisted the supervisee in integrating different techniques.

_____8). Supervisor conveyed active interest in helping supervisee grow professionally.

_____9). Supervisor maintained appropriate and useful level of focus in supervision.

_____10.) Supervisor was respectful of differences in culture, ethnicity or other individual differences 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 I

Weekly Clinical Supervision Form

Postdoc Weekly Supervision Summary Form

Training Objective: _____
Dates of Scheduled Supervision: _____
Duration of Scheduled Individual Supervision: _____
Duration of Scheduled Group Supervision: _____
Supervisor: _____ Fellow: _____

Unscheduled Supervision

Day of Week	Face to Face Individual Hours	Face to Face Group Hours
Monday		
Tuesday	7) _____	_____
_____*ualization*		
Wednesday		
Thursday		
Friday		

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

_____ Fellow description of case
_____ Supervisor's observation of assessment/ therapy session
_____ Supervisor's observation of team/referral source consultation
_____ Observation of Supervisor by fellow
_____ Observation of Adjunct Supervisor by fellow
_____ Discussion of scholarly material relevant to case
_____ Outcome data reviewed
_____ Audio Available
_____ Audio Reviewed
_____ Video Available
_____ Video Reviewed
_____ Other: _____

MEDICAL RECORD DOCUMENTATION REVIEWED THIS WEEK:
____Yes _____No

COMPETENCIES ADDRESSED DURING WEEK'S SCHEDULED AND UNSCHEDULED SUPERVISION (Check all that were addressed)

1. Integration of Science and Practice _____
2. Individual and Cultural Diversity _____
3. Ethical Legal Standards and Policy _____
4. Consultation and Advocacy _____
5. Officer Development _____
6. Professionalism _____
7. Reflective Practice/Self-Assessment/Self-Care_____

POSITIVE FEEDBACK PROVIDED TO FELLOW:
_____ No _____ Yes, as follows: _____

_____

_____

CONSTRUCTIVE FEEDBACK PROVIDED TO FELLOW:
_____ No _____Yes, as follows: _____

_____

SSUES PRETAINING TO THE SUPERVISORY RELATIONSHIP DISCUSSED:
_____ No _____Yes, as follows: _____

_____

Supervisor_____ Fellow: _____

Appendix J

Fellow Grand Rounds Presentation Rating Form

Fellow Grand Rounds Presentation Rating Form

Completed by: _____
Date: _____
Presentation Title: _____

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. Fellow demonstrated expertise and competence 1 2 3 4 5 in the subject.

2. Fellow presented material in clear and orderly fashion. 1 2 3 4 5

3. Fellow presented material at a level and in a manner 1 2 3 4 5
that facilitated audience learning.

4. Fellow paced material well. 1 2 3 4 5

5. Fellow responded adequately to questions and 1 2 3 4 5 other needs of the audience.

6. Fellow's presentation style was engaging and professional 1 2 3 4 5
(eye contact with audience, audible speech, conversational style rather than reading directly from slides).

APPENDIX K

Navy Fitness Report

FITNESS REPORT & COUNSELING RECORD (W2-O6)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix)		2. Grade/Rate	3. Desig	4. SSN
5. ACT ☐ FTS ☐ INACT ☐ AT/ADSW/ 265 ☐	6. UIC	7. Ship/Station	8. Promotion Status	9. Date Reported
Occasion for Report 10. Periodic ☐ Detachment 11. of Individual ☐ Detachment of 12. Reporting Senior ☐ 13. Special ☐			Period of Report 14. From: 15. To:	
16. Not Observed Report ☐	Type of Report 17. Regular ☐ 18. Concurrent ☐ 19. OpsCdr ☐		20. Physical Readiness	21. Billet Subcategory (if any)
22. Reporting Senior (Last, FI MI)	23. Grade	24. Desig	25. Title	26. UIC / 27. SSN
28. Command employment and command achievements.				
29. Primary/Collateral/Watchstanding duties. (Enter primary duty abbreviation in box.) ☐				
For Mid-term Counseling Use. (When completing FITREP, enter 30 and 31 from counseling worksheet, sign 32.)	30. Date Counseled	31. Counselor	32. Signature of Individual Counseled	

PERFORMANCE TRAITS: 1.0 - Below standards/not progressing or UNSAT in any one standard; 2.0 - Does not yet meet all 3.0 standards; 3.0 - Meets all 3.0 standards; 4.0 - Exceeds most 3.0 standards; 5.0 - Meets overall criteria and most of the specific standards for 5.0. Standards are not all inclusive.

PERFORMANCE TRAITS	1.0* Below Standards	2.0 Pro-gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards
33. PROFESSIONAL EXPERTISE: Professional knowledge proficiency, and qualifications. NOB ☐	-Lacks basic professional knowledge to perform effectively. -Cannot apply basic skills. -Fails to develop professionally or achieve timely qualifications.	- - -	-Has thorough professional knowledge. -Competently performs both routine and new tasks. -Steadily improves skills, achieves timely qualifications.	- - -	-Recognized expert, sought after to solve difficult problems. -Exceptionally skilled, develops and executes innovative ideas. -Achieves early/highly advanced qualifications.
34. COMMAND OR ORGANIZATIONAL CLIMATE/EQUAL OPPORTUNITY: Contributing to growth and development, human worth, community. NOB ☐	-Actions counter to Navy's retention/ reenlistment goals. -Uninvolved with mentoring or professional development of subordinates. -Actions counter to good order and discipline and negatively affect Command/ Organizational climate. -Demonstrates exclusionary behavior. Fails to value differences from cultural diversity.	- - - -	-Positive leadership supports Navy's increased retention goals. Active in decreasing attrition. -Actions adequately encourage/support subordinates' personal/professional growth. -Demonstrates appreciation for contributions of Navy personnel. Positive influence on Command climate. -Values differences as strengths. Fosters atmosphere of acceptance/inclusion per EO/EEO policy.	- - - -	-Measurably contributes to Navy's increased retention and reduced attrition objectives. -Proactive leader/exemplary mentor. Involved in subordinates' personal development leading to professional growth/sustained commitment. -Initiates support programs for military, civilian, and families to achieve exceptional Command and Organizational climate. -The model of achievement. Develops unit cohesion by valuing differences as strengths.
35. MILITARY BEARING/ CHARACTER: Appearance, conduct physical fitness, adherance to Navy Core Values. NOB ☐	-Consistently unsatisfactory appearance. -Unsatisfactory demeanor or conduct. -Unable to meet one or more physical readiness standards. -Fails to live up to one or more Navy Core Values: HONOR, COURAGE, COMMITMENT.	- - - -	-Excellent personal appearance. -Excellent demeanor or conduct. -Complies with physical readiness program. -Always lives up to Navy Core Values: HONOR, COURAGE, COMMITMENT.	- - - -	-Exemplary personal appearance. -Exemplary representative of Navy. -A leader in physical readiness. -Exemplifies Navy Core Values: HONOR, COURAGE, COMMITMENT.
36. TEAMWORK: Contributions toward team building and team results. NOB ☐	-Creates conflict, unwilling to work with others, puts self above team. -Fails to understand team goals or teamwork techniques. -Does not take direction well.	- - -	-Reinforces others' efforts, meets personal commitments to team. -Understands team goals, employs good teamwork techniques. -Accepts and offers team direction.	- - -	-Team builder, inspires cooperation and progress. -Talented mentor, focuses goals and techniques for team. -The best at accepting and offering team direction.
37. MISSION ACCOMPLISHMENT AND INITIATIVE: Taking initiative, planning/prioritizing, achieving mission. NOB ☐	-Lacks initiative. -Unable to plan or prioritize. -Does not maintain readiness. -Fails to get the job done.	- - - -	-Takes initiative to meet goals. -Plans/prioritizes effectively. -Maintains high state of readiness. -Always gets the job done.	- - - -	-Develops innovative ways to accomplish mission. -Plans/prioritizes with exceptional skill and foresight. -Maintains superior readiness, even with limited resources. -Gets jobs done earlier and far better than expected.

NAVPERS 1610/2 (11-11) FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE

FITNESS REPORT & COUNSELING RECORD (W2-O6) (cont 'd)

RCS BUPERS 1610-1

1. Name (Last, First MI Suffix)	2. Grade/Rate	3. Desig	4. SSN
SAILOR	LT		

PERFORMANCE TRAITS	1.0 Below Standards	Pro-gressing	3.0 Meets Standards	4.0 Above Standards	5.0 Greatly Exceeds Standards
38. LEADERSHIP: Organizing, motivating and developing others to accomplish goals. NOB ☐	- Neglects growth/development or welfare of subordinates. - Fails to organize, creates problems for subordinates. - Does not set or achieve goals relevant to command mission and vision. - Lacks ability to cope with or tolerate stress. - Inadequate communicator. - Tolerates hazards or unsafe practices.	-	- Effectively stimulates growth/development in subordinates. - Organizes successfully, implementing process improvements and efficiencies. - Sets/achieves useful realistic goals that support command mission. - Performs well in stressful situations. - Clear, timely communicator. - Ensures safety of personnel and equipment.	-	- Inspiring motivator and trainer, subordinates reach highest level of growth and development. - Superb organizer, great foresight, develops process improvements and efficiencies. - Leadership achievements dramatically further command mission and vision. - Perseveres through the toughest challenges and inspires others. - Exceptional communicator. - Makes subordinates safety-conscious, maintains top safety record. - Constantly improves the personal and professional lives of others.
39. TACTICAL PERFORMANCE: (Warfare qualified officers only) Basic and tactical employment of weapons systems. NOB ☐	- Has difficulty attaining qualification expected for the rank and experience. - Has difficulty in ship(s), aircraft or weapons systems employment. Below others in knowledge and employment. - Warfare skills in specialty are below standards compared to others of same rank and experience.	-	- Attains qualifications as required and expected. - Capably employs ship(s), aircraft, or weapons systems. Equal to others in warfare knowledge and employment. - Warfare skills in specialty equal to others of same rank and experience.	-	- Fully qualified at appropriate level for rank and experience. - Innovatively employs ship(s), aircraft, or weapons systems. Well above others in warfare knowledge and employment. - Warfare skills in specialty exceed others of same rank and experience.

40. I recommend screening this individual for next career milestone(s) as follows: (maximum of two)
Recommendations may be for competitive schools or duty assignments such as:
SCP, Dept Head, XO, OIC, CO, Major Command, War College, PG School.

41. COMMENTS ON PERFORMANCE: * All 1.0 marks, three 2.0 marks, and 2.0 marks in Block 34 must be specifically substantiated in comments. Comments must be verifiable. Font must be 10 or 12 Pitch (10 or 12 Point) only. Use upper and lower case.

Promotion Recommendation	NOB	Significant Problems	Progressing	Promotable	Must Promote	Early Promote	44. Reporting Senior Address
42. INDIVIDUAL	X						
43. SUMMARY	X	0	0	1	1	6	

45. Signature of Reporting Senior
Date:

46. Signature of Individual evaluated. "I have seen this report, been apprised of my performance, and understand my right to submit a statement."
I intend to submit a statement. ☐ I do not intend to submit a statement. ☐
Date:

Member Trait Average: 0.00 Summary Group Average: 3.58

47. Typed name, grade, command, UIC, and signature of Regular Reporting Senior on Concurrent Report
Date:

NAVPERS 1610/2 (11-11) FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE

Appendix L
Graduate Medical and Dental Education
Adverse Action and Due Process Policy

GRADUATE MEDICAL & DENTAL EDUCATION
NAVAL MEDICAL
CENTER 620 JOHN PAUL
JONES CIRCLE
PORTSMOUTH, VIRGINIA

15 MAR 2024

Graduate Medical and Dental Education
Adverse Academic Action and Due Process Policy

Ref: (a) ACGME Institutional Requirements – effective 7-1-2022
(b) DHA-PI 1025.04
(c) NAVMEDCENPSVAINST 5420.29 Graduate Medical and Dental Education
(d) NMCP Graduate Medical and Dental Education Resident Grievance Policy

1. Purpose: To outline the range of potential adverse academic actions and due process policy for Graduate Medical and Dental Education (GMDE) trainees, per instruction in references (a-c).

2. Background:

   a. Medical and dental officers enrolled in military sponsored GMDE programs are expected to:

      i. Acquire the requisite knowledge, skills, and abilities (KSAs) to achieve program completion, as outlined by the program's curriculum as well as Defense Health Agency (DHA), military department (MILDEP), Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties (ABMS), and other certifying body requirements. The ACGME Core Competencies are key components of these KSAs.

      ii. Comply with the professional standards and ethics expected of a GMDE trainee and an officer in the Uniformed Services.

   b. Program Directors (PDs), along with their program's Clinical Competency Committee (CCC), monitor trainee progress toward program completion, and periodic feedback is provided to trainees to improve performance and assist in program completion.

   c. Trainees' KSAs may, at some point during their training, be below an expected milestone for their level. As described in reference (b), there is generally a stepwise approach to address these issues, beginning with corrective feedback, followed by an update to the individual learning plan (ILP), and then an improvement plan (i.e., "Program-Level Remediation").

      i. Program-level remediation:

         1. Is handled at the program level and does not have command-level oversight.

2. Is NOT considered adverse academic action but rather a part of the normal feedback process. It is a tool used for success to avoid adverse academic action.

3. Is NOT required to be documented in the formal end of training evaluation (DHA Form 165) or reported to accrediting or privileging bodies.

ii. PDs should provide specific counseling to the trainee about what the documented deficiencies are and the plan to address and overcome these deficiencies.

iii. These actions will be thoroughly discussed with the trainee and documented in their training record. This counseling of the trainee as well as documentation is critical to any potential future adverse academic action process.

iv. For trainees with performance problems, it is common that a health condition or external life stressors could be potential contributing factors. PDs should advise any trainee being considering for a written individualized improvement plan or adverse academic action of available resources to assist with any such contributing factors, should the trainee wish to pursue assistance. PDs may also consider if a voluntary leave of absence may be an appropriate course of action for acute challenges.

v. Depending on the nature of the issue(s) (e.g., for a single incident of gross negligence or willful misconduct), it may be appropriate to bypass program-level remediation and go directly to administrative related absence from training (ARAFT), probation, or termination as the initial action.

d. Trainees may also, at some point in their training, require an extended absence from training for health-related or administrative reasons.

i. These are known as a health-related absence from training (HRAFT) or administrative-related absence from training (ARAFT), respectively. HRAFTS and ARAFTS both require review and approval by the Executive Committee of the GMDEC (ECGMDEC).

ii. These are NOT adverse academic actions but do typically necessitate an extension of training.

iii. Depending on the circumstances, if an evaluation related to an ARAFT results in an adverse academic action, then the ARAFT is termed a suspension.

iv. See reference (b) for further details on HRAFTs and ARAFTs.

3. Definitions:

a. Program-Level Remediation: A formal process designed to help trainees meet program-specific KSAs in the domains of the core competencies. The PD, in consultation with the CCC, is charged with approving this plan and monitoring progression. Program-level remediation is NOT

considered an adverse academic action.

b. Adverse Academic Action: A change in academic standing which is reportable to outside agencies on DHA Form 165 (i.e., "GME Final Evaluation" or "Summative Evaluation") and can take the form of probation, suspension, or termination from training.

c. Probation: A type of adverse academic action that a PD, in consultation with the CCC, may recommend for a trainee after a program-level remediation fails or in response to a single incident of gross negligence or willful misconduct.

d. Suspension: A period of administrative-related absence from training which is retrospectively termed a suspension if the issue in question ultimately results in an approved adverse academic action.

e. Termination: Removal of a trainee from a training program prior to program completion. Causes for termination include, but are not limited to, performance below expected levels, ethical issues, safety concerns, failure to promote, and/or unprofessional conduct.

f. Due Process: A formal process that ensures that decisions are made in a fair and consistent manner.

4. Policy:

a. General Policy:

i. Probation, suspension, and termination are command-level adverse academic actions which require approval of the Executive Committee of the GMDEC (ECGMDEC).

ii. Adverse academic actions typically begin when a program's CCC reviews a trainee's educational record and makes a recommendation to the PD.

iii. If the PD concurs with the CCC's recommendation for an adverse academic action, the PD will submit a proposal to the ECGMDEC.

iv. Alternatively, if at any time it is determined that a trainee presents a potential danger to themselves, others, and/or their patients then a PD may summarily suspend training status while an investigation is conducted.

1. In this case, the PD will immediately investigate and either suspend the trainee's patient care activities (place them on an ARAFT) or document confidence in the trainee. If the trainee's patient care activities are suspended, the PD will make recommendations for action to the ECGMDEC within 5 days of the date of suspension. The DPE/DIO will notify the trainee of the recommendation.

2. If the trainee wishes to contest the recommendation, he/she will have 10 business days to request an appeal, in writing, to the DPE/DIO. A hearing following paragraph 4e below will be convened to consider appropriate action.

v. The ECGMDEC serves as the NAVMEDCEN authority to review and either approve or reject proposed trainee adverse academic actions. The constituents of the ECGMDEC are outlined in reference (c). Notably, at least one trainee representative must be on the committee

and present for voting.

vi. All adverse academic action proposals or plans will be applied in a uniform and fair manner by the ECGMDEC in order to avoid any arbitrary or capricious actions.

vii. PDs will provide trainees with written notification of a proposed adverse academic action. The written notice must include language indicating that suspension with a conclusive investigation, probation, and/or termination is an adverse academic action and a reportable event.

viii. With exception of voting deliberations, trainees have the right to be physically or virtually present for the ECGMDEC's review of an adverse academic proposal. Trainees have the right to provide a written or oral statement for the ECGMDEC's review. Written statements should typically be provided by the trainee within 10 business days of notification by their PD of a proposed adverse academic action.

ix. As the trainee had the opportunity to participate in the ECGMDEC's review of the adverse academic action proposal, all decisions for probation are final. Decisions for termination, however, may be appealed by the trainee (see paragraphs 4d and 4e).

x. Per reference (a), trainees will be provided written notification as well as appropriate due process in all instances of trainee suspension, termination, non-promotion to the next level of training, or non-renewal of appointment.

xi. Samples/templates for written notifications to trainees are available from the NMCP GMDE Office.

xii. Trainees have the right to grieve any recommendation for adverse academic action. Such grievances (and all other grievances) will occur in accordance with references (b) and (d).

b. Probation:

i. Probation should be recommended when deficiency(s) are to the degree that, if not corrected, will likely result in the trainee not completing the program.

ii. Its purpose is to impress upon the trainee the seriousness of their deficiency or misconduct and to give the trainee the opportunity to correct those deficiencies.

iii. PDs may recommend probation after a program-level remediation fails OR in response to a single incident of gross negligence or willful misconduct.

iv. The PD will present the case to the ECGMDEC, including documentation of remediation actions taken to date and the trainee's progress. The PD will also present a proposed plan of command-level probation for review and ultimate approval or rejection by the ECGMDEC.

v. If the probation proposal is not approved by the ECGMDEC, the PD will consult with the program's CCC and formulate an alternative plan, as appropriate.

vi. If the probation proposal is approved, the duration of probation will normally be for three to six months but may be longer.

vii. Command-level probation will be documented by providing written notification to the trainee informing them of:

1. the specific ACGME competency-linked deficiencies, acts, or circumstances for which the probation is imposed,

2. the planned duration of probation,

3. and specific recommendations to assist the trainee in overcoming the deficiencies.

viii. The ECGMDEC will regularly review the progress of any trainees on probationary status.

1. If satisfactory progress is made, probationary status may be removed by the ECGMDEC upon the recommendation of the PD.

2. If satisfactory progress has not been demonstrated within the probation timeline, the PD will make a recommendation to the ECGMDEC for either an additional period of probation or termination of training (explained in paragraph 4d).

3. The ECGMDEC holds ultimate authority in recommending an additional period of probation or termination.

ix. For trainees who successfully complete a probation plan and return to normal academic training status, PDs may extend the trainee's time required for program completion. The length of training extension is typically equal to the period(s) of probation; however, the PD may also determine that no extension is required for program completion.

x. Any extension of training must be submitted via the chain of command for approval. An extension could result in an additional ADSO.

c. Suspension:

i. If a trainee presents a potential danger to themselves, others, and/or their patients, PDs will recommend placement of the trainee on an ARAFT while an investigation is conducted. ARAFTs require review and approval of the ECGMDEC.

ii. If the circumstances of that investigation ultimately result in an approved academic probation or termination, the ARAFT is classified as a suspension and is a reportable event on the DHA Form 165.

d. Termination:

i. Termination is the most serious action that can be recommended by the ECGMDEC and generally occurs when a trainee has had at least one episode of probation or suspension

without tangible evidence of remediation by the trainee to perform at a satisfactory level.

ii. Trainees who fail to demonstrate satisfactory progress after two consecutive periods of probation will normally be recommended for termination.

iii. Termination may also be recommended in the case of a single incident of gross negligence or misconduct without having gone through a period of an improvement plan, probation, and/or suspension.

iv. Termination proposals will consist of the following elements: deficiencies that are comprehensive, specific, and linked to ACGME competency(s), summary of previous efforts to improve performance (if applicable), and analyses of why further training in the specialty is not appropriate.

v. If the termination proposal is not approved by the ECGMDEC, the PD will consult with the program's CCC and formulate an alternative plan, as appropriate.

vi. If the termination proposal is approved by the ECGMDEC, the recommendation for termination will be forwarded to the Commander/MTF Director (or equivalent), who is the final authority for termination of training.

vii. A trainee has the right to appeal a recommendation for termination (probation decisions, however, are final). If the trainee wishes to do so, the trainee will have 10 business days from receipt of written formal notification of the recommendation to request an appeal, in writing, to the DIO/DPE. Note that the DIO/DPE is not a member of the ECGMDEC, which is chaired by the Assistant DIO. The DIO/DPE will review the termination recommendation, ensuring that due process was followed, and will submit a recommendation to the Commander/MTF Director (or equivalent).

1. An appeal hearing will be convened to consider appropriate action (following guidelines in paragraph 4e below).

2. Failure to request an appeal in writing within the above timeframe constitutes a waiver by the trainee of his or her right to a review.

viii. If termination is confirmed, the PD will complete the trainee's final summative evaluation.

ix. The DIO/DPE will immediately notify the trainee's parent MILDEP GME Director within two business days of a trainee's termination from training.

x. Trainees terminated from a GME program may be subject to an ADSO as per regulation and contract agreement of respective MILDEP.

xi. The trainee's follow-on assignment is determined by the respective MILDEP.

e. ECGMDEC Review of Adverse Academic Action Proposals:

i. Review hearings for adverse academic action proposals will typically be scheduled within

10 business days. They are not bound by the formal rules of evidence or a strict procedural format.

ii. The ECGMDEC may question witnesses and examine documents as necessary. The DHA Office of General Council will provide a non-voting legal advisor to the ECGMDEC.

iii. Trainee is entitled to certain rights for review hearings:

1. Right not to participate in the hearing and/or remain silent.

2. Right to obtain notice of the grounds for the action.

3. Right to obtain copies of documents to be considered by the ECGMDEC.

4. Right to know who will testify at the hearing.

5. Right to seek military defense counsel or to secure civilian defense counsel at his/her own expense. NOTE: The presence of counsel at the hearing is not an absolute right. Legal Counsel may advise the trainee during the session, but only the trainee may address the ECGMDEC and/or witnesses. Legal Counsel may be excluded from the hearing if counsel's presence unduly impedes the hearing, as per the panel chair's judgment.

6. Right to present evidence at the hearing.

7. Right to ask questions to those testifying at the hearing.

8. Right to make an oral or written statement in his/her own behalf, if they so choose (written statements should typically be provided by the trainee within 10 business days of notification by their PD).

iv. The DIO may authorize a review hearing to be held without the trainee, if the trainee declines being present or does not respond within the typical period of 10 business days of a hearing being scheduled. In this case, all the same rights apply, except the following:

1. The right to present evidence is limited to providing written documentation prior to the meeting.

2. There is no right to ask questions to those testifying at the hearing.

3. Right to make a statement in his/her own behalf is limited to a written statement provided prior to the meeting.

v. The trainee will receive notice of these rights, to be delivered to the trainee in-person, by official e-mail, or by registered or certified mail, with a return receipt requested.

vi. A record of the summary of the proceeding will be drafted and maintained by the DIO/DPE's office. The trainee may request a copy of this summary.

vii. After evidence has been reviewed, the voting members of the ECGMDEC will deliberate confidentially (without the trainee's presence). For probation, the action is approved by a simple majority vote. For termination, the action is sent forth to the higher authority (CO) by a two-thirds majority vote.

f. Resignation from training:

i. Trainees may request resignation from their program in writing. This written request should be directed to the PD who will make his or her recommendation to the DIO/DPE for review and approval. This process is further detailed in reference (b).

ii. DIO/DPE will provide written notification to the respective MILDEP GME Office of trainees who resign. MILDEP-level GME policy will be reviewed for guidance regarding additional requirements that need to be met for GME program resignation.

iii. Trainees who resign may/may not be eligible for further GME in accordance with MILDEP needs and policy.

iv. Those resignations which are submitted in lieu of potential adverse academic action may be referred for consideration to the ECGMDEC as appropriate.

v. For trainees who resign after being given written notice of a proposal for an adverse academic action, the resignation will be annotated on the summative evaluation as "resigned after receiving written notice of a proposal for suspension, probation, or termination."

g. Uniform Code of Military Justice (UCMJ) Violations:

i. Per reference (b), the MILDEPs retain responsibility for processing trainees due to any alleged UCMJ violations.

LAIL.MATSEPH.1386424264 Digitally signed by LAIL.MATTHEW.JOSEPH.1386424264 Date: 2024.04.29 09:50:43 -04'00' 15MAR 2024

Matthew J. Lail, LCDR, MC, USN Date
Chair, Policy Subcommittee

TSCHANETER.1253038850 Digitally signed by TSCHANZ.MARK.PETER.1253038850 Date: 2024.04.29 11:40:32 -04'00' 15 MAR 2024

Mark P. Tschanz, CAPT, MC, USN Date Designated Institutional Official
Chair, Graduate Medical and Dental Education Committee

GMDEC Review and Approval Date: 15 MAR 2024

Appendix M

Adverse Pathways

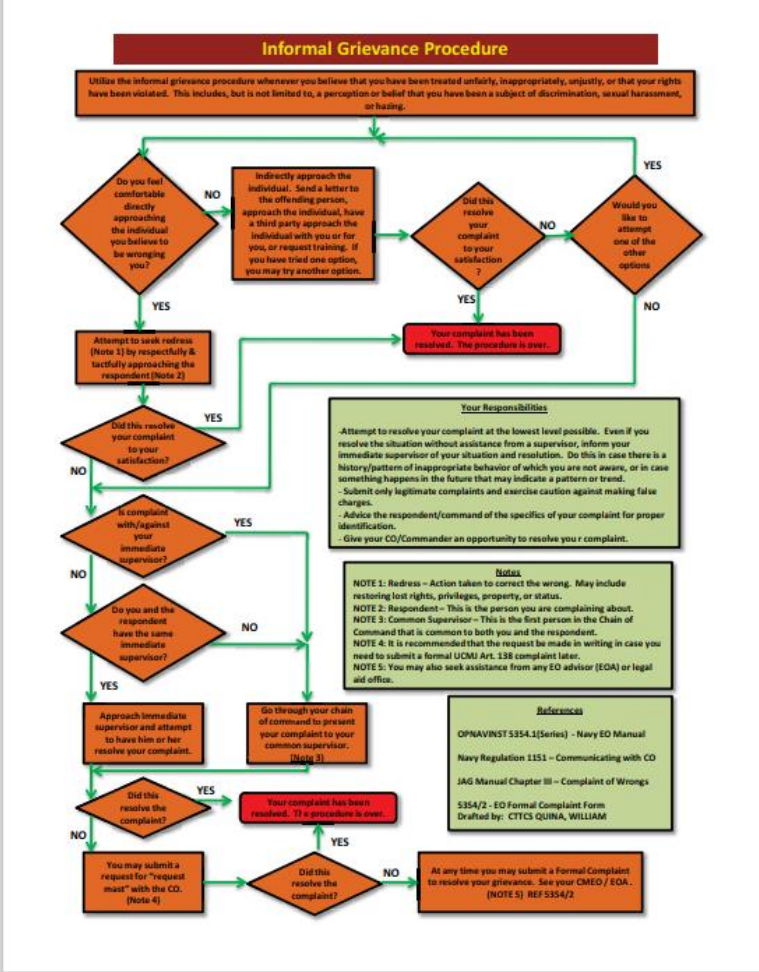
Appendix FF

Command Equal Opportunity Program

https://esportal.med.navy.mil/nmcp/cmteorg/cmeo

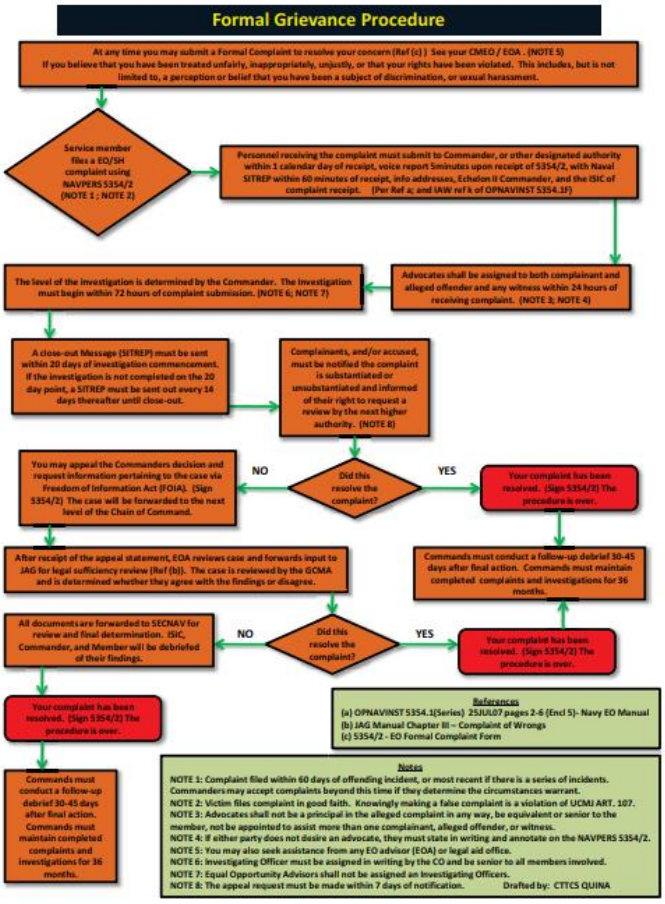
Appendix GG

Informal Grievance Procedure



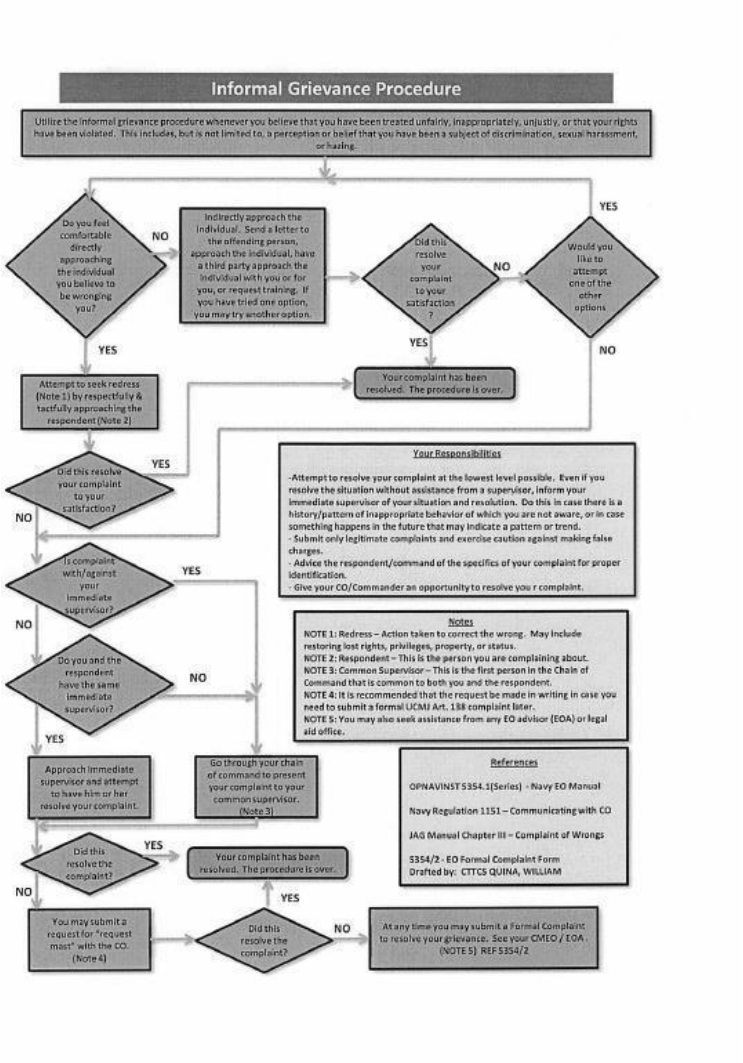
Appendix HHF

Formal Grievance Procedure



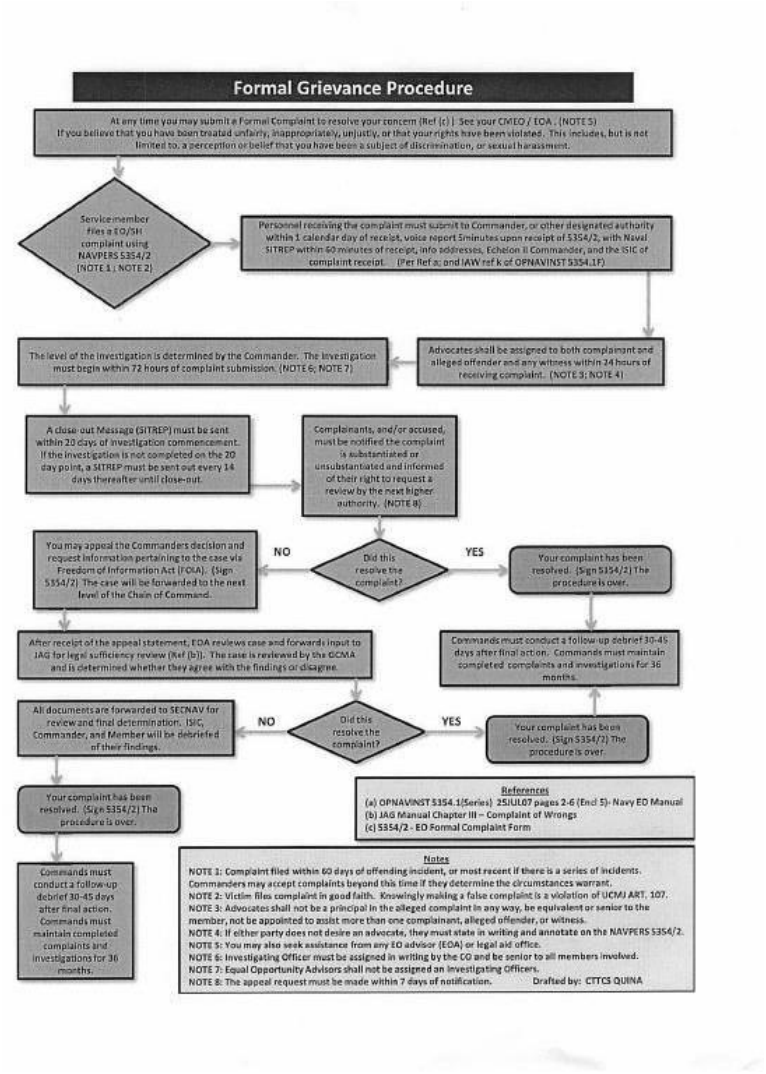
Appendix O

Informal Grievance Procedure


Informal Grievance Procedure
Utilize the informal grievance procedure whenever you believe that you have been treated unfairly, inappropriately, unjustly, or that your rights have been violated. This includes, but is not limited to, a perception or belief that you have been a subject of discrimination, sexual harassment, or hazing.
Do you feel comfortable directly approaching the individual you believe to be wronging you?
NO
Indirectly approach the individual. Send a letter to the offending person, approach the individual, have a third party approach the individual with you or for you, or request training. If you have tried one option, you may try another option.
Did this resolve your complaint to your satisfaction ?
NO
Would you like to attempt one of the other options
YES
YES
YES
NO
Attempt to seek redress (Note 1) by respectfully & tactfully approaching the respondent (Note 2)
Your complaint has been resolved. The procedure is over.
Did this resolve your complaint to your satisfaction?
YES
NO
Your Responsibilities
-Attempt to resolve your complaint at the lowest level possible. Even if you resolve the situation without assistance from a superviser, inform your immediate supervisor of your situation and resolution. Do this in case there is a history/pattern of inappropriate behavior of which you are not aware, or in case something happens in the future that may indicate a pattern or trend.
- Submit only legitimate complaints and exercise caution against making false charges.
- Advice the respondent/command of the specifics of your complaint for proper identification.
- Give your CO/Commander an opportunity to resolve you r complaint.
Is complaint with/against your immediate supervisor?
YES
NO
Notes
NOTE 1: Redress – Action taken to correct the wrong. May include restoring lost rights, privileges, property, or status.
NOTE 2: Respondent – This is the person you are complaining about.
NOTE 3: Common Supervisor – This is the first person in the Chain of Command that is common to both you and the respondent.
NOTE 4: It is recommended that the request be made in writing in case you need to submit a formal UCMJ Art. 138 complaint later.
NOTE 5: You may also seek assistance from any EO advisor (EOA) or legal aid office.
Do you and the respondent have the same immediate supervisor?
NO
YES
Approach immediate supervisor and attempt to have him or her resolve your complaint.
Go through your chain of command to present your complaint to your common supervisor. (Note 3)
References
OPNAVINST 5354.1(Series) - Navy EO Manual
Navy Regulation 1151 – Communicating with CO
JAG Manual Chapter III – Complaint of Wrongs
5354/2 - EO Formal Complaint Form
Drafted by: CTTCS QUINA, WILLIAM
Did this resolve the complaint?
YES
Your complaint has been resolved. The procedure is over.
NO
YES
You may submit a request for "request mast" with the CO. (Note 4)
Did this resolve the complaint?
NO
At any time you may submit a Formal Complaint to resolve your grievance. See your CMEO / EOA . (NOTE 5) REF 5354/2

Appendix P

Formal Grievance Procedure


Formal Grievance Procedure
At any time you may submit a Formal Complaint to resolve your concern (Ref (c)). See your CMEO / EOA . (NOTE 5)
If you believe that you have been treated unfairly, inappropriately, unjustly, or that your rights have been violated. This includes, but is not limited to, a perception or belief that you have been a subject of discrimination, or sexual harassment.
Service member files a EO/SH complaint using NAVPERS 5354/2 (NOTE 1 ; NOTE 2)
Personnel receiving the complaint must submit to Commander, or other designated authority within 1 calendar day of receipt, voice report 5minutes upon receipt of 5354/2, with Naval SITREP within 60 minutes of receipt, info addresses, Echelon II Commander, and the ISIC of complaint receipt. (Per Ref a; and IAW ref k of OPNAVINST 5354.1F)
Advocates shall be assigned to both complainant and alleged offender and any witness within 24 hours of receiving complaint. (NOTE 3; NOTE 4)
The level of the investigation is determined by the Commander. The investigation must begin within 72 hours of complaint submission. (NOTE 6; NOTE 7)
A close-out Message (SITREP) must be sent within 20 days of investigation commencement. If the investigation is not completed on the 20 day point, a SITREP must be sent out every 14 days thereafter until close-out.
Complainants, and/or accused, must be notified the complaint is substantiated or unsubstantiated and informed of their right to request a review by the next higher authority. (NOTE 8)
Did this resolve the complaint?
NO
YES
You may appeal the Commanders decision and request information pertaining to the case via Freedom of Information Act (FOIA). (Sign 5354/2) The case will be forwarded to the next level of the Chain of Command.
Your complaint has been resolved. (Sign 5354/2) The procedure is over.
After receipt of the appeal statement, EOA reviews case and forwards input to JAG for legal sufficiency review (Ref (b)). The case is reviewed by the GCMA and is determined whether they agree with the findings or disagree.
Commands must conduct a follow-up debrief 30-45 days after final action. Commands must maintain completed complaints and investigations for 36 months.
All documents are forwarded to SECNAV for review and final determination. ISIC, Commander, and Member will be debriefed of their findings.
Did this resolve the complaint?
NO
YES
Your complaint has been resolved. (Sign 5354/2) The procedure is over.
Your complaint has been resolved. (Sign 5354/2) The procedure is over.
References
(a) OPNAVINST 5354.1(Series) 25JUL07 pages 2-6 (Encl 5)- Navy EO Manual
(b) JAG Manual Chapter III – Complaint of Wrongs
(c) 5354/2 - EO Formal Complaint Form
Commands must conduct a follow-up debrief 30-45 days after final action. Commands must maintain completed complaints and investigations for 36 months.
Notes
NOTE 1: Complaint filed within 60 days of offending incident, or most recent if there is a series of incidents. Commanders may accept complaints beyond this time if they determine the circumstances warrant.
NOTE 2: Victim files complaint in good faith. Knowingly making a false complaint is a violation of UCMJ ART. 107.
NOTE 3: Advocates shall not be a principal in the alleged complaint in any way, be equivalent or senior to the member, not be appointed to assist more than one complainant, alleged offender, or witness.
NOTE 4: If either party does not desire an advocate, they must state in writing and annotate on the NAVPERS 5354/2.
NOTE 5: You may also seek assistance from any EO advisor (EOA) or legal aid office.
NOTE 6: Investigating Officer must be assigned in writing by the CO and be senior to all members involved.
NOTE 7: Equal Opportunity Advisors shall not be assigned an investigating Officers.
NOTE 8: The appeal request must be made within 7 days of notification.
Drafted by: CITCS QUINA

Appendix Q

Appendix R Supervisor Evaluation Form
Supervisor Evaluation Form

Fellow's Evaluation of Supervisor for the _____Rotation

Fellow: _____
Supervisor: _____
Date: _____

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 3 Advanced Competencies and 4 Focused, Program Specific Competencies used to inform all of our training objectives.

Use the following rating scale: 1 = Poor

2 = Marginal

3 = Adequate

4 = Good

5 = Excellent

_____ Integration of Science and Practice

_____ Individual and Cultural Diversity

_____ Ethical Legal Standards and Policy

_____ Consultation and Advocacy

_____ Officer Development

_____ Professionalism

_____ Reflective Practice/Self-Assessment/Self-Care

Additional Comments:

_____

_____

_____

_____

_____

_____ _____

Fellow Supervisor

APPENDIX S

Fellow's Mid-year Evaluation of Program Form

Fellow's Mid-year Evaluation of Program Form

Mid-year Program Evaluation

Fellow: _____ Date: _____

Please provide your views of various experiences you have had up to this point in the training year. Circle the appropriate number, 1-5, as provided below.

1. Spending one month on inpatient/ER psychiatry at the beginning of the training year was very helpful.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

2. The quality of the supervision I received on inpatient/ER psychiatry was very good.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

3. The didactics I have attended been very informative.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

4. Participation in didactics has given me practical skills.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

5. I see a clear value to the Lunch and Learn Seminars, Group Supervision, and Protocol Therapy Supervision.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

6. I believe the training staff does a good job of treating me with dignity and respect.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

7. An appreciation of personal and cultural difference (i.e., opinions and ideas) is demonstrated by training staff.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

8. I consistently know who is covering for my supervisors if they are absent from the work space.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

9. Overall, I am satisfied with this postdoctoral training program.
   1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Please list the best didactics you have attended:

_____

Please list the least helpful didactics you have attended:

Additional Comments:

As the final component of this mid-year evaluation, please rate the training program, as a whole, in terms of its adequacy in addressing each of the 3 Advanced Competencies and 4 Focused, Program Specific Competencies that serve as the basis for structuring this program.

Use the following rating scale: 1 = Poor

2 = Marginal

3 = Adequate

4 = Good

5 = Excellent

____ Integration of Science and Practice

____ Individual and Cultural Diversity

____ Ethical Legal Standards and Policy

____ Consultation and Advocacy

____ Officer Development

____ Professionalism

____ Reflective Practice/Self-Assessment/Self-Care

Additional Comments:

_____
_
_____
_
_____
_
_____
_ _____

Commented [MF1]: What?

Signature Date

APPENDIX T

Fellow's End-of-Year Evaluation of Program Form

End of Year Training Program Evaluation

Fellow: _____
Date: _____

Please provide feedback regarding the quality of each component of our training program. Your input is essential to our process improvement efforts on behalf of this program. 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 pages if needed.

The application process for this program: _____

Orientation procedures over the first two weeks of the program

Inpatient/ER Rotation: _____

Substance/Alcohol Abuse Mini-Rotation: _____

Embedded Rotation: _____

Specialty rotation (_____):

General Outpatient Rotation:

_____
_
_____
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_____
_
_____

Other operational experiences (if applicable):

_____
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Didactics:

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Prolonged Exposure and/or Cognitive Processing Therapy Treatment Workshops:

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_____

Lunch and Learn Seminars:

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Supervision of pre-doctoral students (when available):

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_____
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Dr. Barbara Cubic's contributions to CBT training:

_____
_____
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_____
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_

What were the best aspects of this training program? _____
_____
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_

Where is improvement needed?

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_

As the final component of this end of year evaluation, please rate the training program, as a whole, in terms of its adequacy in addressing each of the 3 Advanced Competencies and 4 Focused, Program Specific Competencies that serve as the basis for structuring this program.

Use the following rating scale: 1 = Poor

2 = Marginal

3 = Adequate

4 = Good

5 = Excellent

____ Integration of Science and Practice

____ Individual and Cultural Diversity

____ Ethical Legal Standards and Policy

____ Consultation and Advocacy

____ Officer Development

____ Professionalism

____ Reflective Practice/Self-Assessment/Self-Care

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

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

Additional Comments:

_____
_
_____
_
_____
_

Signature_____ Date_____

Appendix U

Program Outcomes Assessment and Monitoring Questionnaire

Outcomes Assessment and Monitoring Questionnaire

* Required

1. **Email address** *

Updates

2. **Name (Last, First)** *

3. **Your training year** *
   Mark only one oval.
   - 2010-2011
   - 2011-2012
   - 2012-2013
   - 2013-2014
   - 2014-2015
   - 2015-2016

4. **Are you currently employed on a full-time basis as a clinical psychologist?** *
   Mark only one oval.
   - Yes
   - No

5. **If no, please describe your current employment status:**

6. **What is your military status?** *
Mark only one oval.

- ◯ Active Duty
- ◯ Reserves
- ◯ Veteran

7. **What is your current rank (or what was your rank when you left the service)?** *

_____

8. **Have you been eligible for promotion since leaving the training program?** *
Mark only one oval.

- ◯ Yes
- ◯ No

9. **If yes, what was the result of your most recent promotion board?**
Mark only one oval.

- ◯ Selected for promotion
- ◯ Not selected for promotion

10. **Have you deployed since leaving the training program?** *
Mark only one oval.

- ◯ Yes
- ◯ No

11. **If yes, in what capacity did you deploy?** *
Mark only one oval.

- ◯ Ship deployment
- ◯ Attached to MTF
- ◯ Embedded (MARSOC, OSCAR, etc)
- ◯ Other: _____

12. **What was your first employment setting after leaving internship (note that APA requires we ask all of these categories)?**
Mark only one oval.

- ◯ Academic teaching
- ◯ Community mental health program
- ◯ Consortium
- ◯ Correctional facility
- ◯ Health maintenance organization
- ◯ Hospital/medical center
- ◯ Independent practice
- ◯ Psychiatric facility
- ◯ School district or system
- ◯ University counseling center
- ◯ Other: _____

13. **What is your current employment setting?** *
Mark only one oval.

- ◯ Academic teaching
- ◯ Community mental health center
- ◯ Consortium
- ◯ Correctional facility
- ◯ Health maintenance organization
- ◯ Hospital/medical center
- ◯ Independent practice
- ◯ Psychiatric facility
- ◯ School district or system
- ◯ University counseling center
- ◯ Other: _____

14. **What is your current job title** *

_____

15. **Are you currently licensed as a clinical psychologist?** *
Mark only one oval.

- ◯ Yes
- ◯ No

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

_____

17. **If no, why are you not licensed (select all that apply)?**
Check all that apply.

- [ ] Dissertation not yet completed or only recently completed
- [ ] I have not yet taken the EPPP.
- [ ] I have taken the EPPP but have not yet passed it.
- [ ] Dissertation and EPPP are complete and am currently applying to a particular state.
- [ ] Other: _____

18. **Are you a member of APA?** *
Mark only one oval.

- ◯ Yes
- ◯ No

19. **If yes, to which divisions to you belong?**

_____

20. **Do you belong to other professional organizations?** *
Mark only one oval.

- ◯ Yes
- ◯ No, and I have no current plans to join any other organizations.
- ◯ No, but I plan to join another organization.

21. **If you belong to other professional organizations, which ones?**

_____

22. **Have you achieved board certification?** *
Mark only one oval.

- ◯ Yes
- ◯ No, currently in process of applying.
- ◯ No, not currently applying.

23. **If board certified or applying, in what area?**

_____

24. **If board certified or applying, through what board?**
Mark only one oval.

- ◯ American Board of Professional Psychology
- ◯ American Academy of Clinical Psychology
- ◯ American Academy of Medical Psychology
- ◯ American Board of Disability Analysts
- ◯ Other: _____

25. **Have you had a manuscript accepted for publication in a peer-reviewed journal in the past year?** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ No, but I have one or more in progress.

26. **If yes, how many manuscripts and in which journals?**

_____

_____

_____

_____

_____

27. **Have you given a presentation at a regional, national, or international conference over the past year?** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ No, but have plans to do so within the next year.

28. **If yes, how many presentations and which conferences?**

_____

_____

_____

_____

_____

29. **Have you provided clinical supervision of an unlicensed or junior colleague in the past year?** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ No, but anticipate doing so over the next year.

30. **If yes, how many hours of clinical supervision have you provided over the past year?**
Mark only one oval.

- ◯ 0-10
- ◯ 11-25
- ◯ 26-50
- ◯ 51-75
- ◯ 76-100
- ◯ more than 100

31. **Have you engaged in teaching activities (e.g., given lecture, presented in Grand Rounds) over the past year?** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ No but have plans to do so in the next year.

32. **If yes, please describe your teaching activities.**

_____

_____

_____

_____

_____

33. **Have you been responsible for administrative tasks linked to your role as a clinical psychologist over the last year?** *
Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ No but have plans to do so over the next year.

34. **If yes, please briefly describe your administrative duties.**

35. **How many hours have you spent over the past year participating in a continuing education (CE) activity?** *
Mark only one oval.

- ◯ none
- ◯ 1-5
- ◯ 6-10
- ◯ 10-20
- ◯ more than 20

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

Skip to question 36.

Training Objectives

This section contains the 7 Foundational and 8 Functional competencies around which our training program is designed. You will be asked to rate your current self-assessed competencies in these training objectives relative to your competency levels at the end of internship. You will then rate the relevance of these competencies to your current practice and your appraisal of how relevant they will be to your future practice. Finally, you will rate how often you engage in activities in each competency domain.

37. **Current competency compared to competency level at the end of the training year:** *

Mark only one oval per row.

	Much worse	Worse	Unchanged	Improved	Much Improved
Professionalism					
Reflective Practice/self-assessment/self-care					
Scientific knowlege and methods					
Relationships					
Individual and cultural diversity					
Ethical legal standards and policy					
Interdisciplinary systems					
Asessment					
Intervention					
Consultation					
Research/evaluation					
Supervision					
Teaching					
Management/Administration					
Advocacy					

38. **Relevance of training to current professional practice:** *

Mark only one oval per row.

	Not relevant	A little relevant	Relevant	Very relevant	Highly relevant
Professionalism					
Reflective Practice/self-assessment/self-care					
Scientific knowlege and methods					
Relationships					
Individual and cultural diversity					
Ethical legal standards and policy					
Interdisciplinary systems					
Asessment					
Intervention					
Consultation					
Research/evaluation					
Supervision					
Teaching					
Management/Administration					
Advocacy					

39. **Anticipated relevance of training to future professional practice:** *

Mark only one oval per row.

	Not relevant	A little relevant	Relevant	Very relevant	Highly relevant
Professionalism					
Reflective Practice/self-assessment/self-care					
Scientific knowlege and methods					
Relationships					
Individual and cultural diversity					
Ethical legal standards and policy					
Interdisciplinary systems					
Asessment					
Intervention					
Consultation					
Research/evaluation					
Supervision					
Teaching					
Management/Administration					
Advocacy					

40. **How often have you engaged in activities in each competency domain in the past year:** *

Mark only one oval per row.

	Not at all	Once or twice	Several times	Many times	Daily
Professionalism					
Reflective Practice/self-assessment/self-care					
Scientific knowlege and methods					
Relationships					
Individual and cultural diversity					
Ethical legal standards and policy					
Interdisciplinary systems					
Asessment					
Intervention					
Consultation					
Research/evaluation					
Supervision					
Teaching					
Management/Administration					
Advocacy					

Satisfaction

41. **Overall, how satisfied are you with how well the training you received at Naval Medical Center Portsmouth prepared you for continued professional growth and development?** *
Mark only one oval.

	1	2	3	4	5	
Extremely Dissatisfied	◯	◯	◯	◯	◯	Extremely Satisfied

42. **Overall, how satisfied are you with how well the training you received at Naval Medical Center Portsmouth prepared you to meet emerging issues and changes in the practice of professional psychology?** *
Mark only one oval.

	1	2	3	4	5	
Extremely Dissatisfied	◯	◯	◯	◯	◯	Extremely Satisfied

43. **What component or aspect of your postdoctoral fellowship training has been the most helpful in your current career?** *

44. **What component or aspect of your post-doctoral fellowship training has been the least helpful in your current career?** *

45. **Please describe anything you wish you had learned/learned more of during your post-doctoral fellowship.** *

46. **Other feedback:**

Send me a copy of my responses.

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Appendix V

Quarterly Learning Climate Survey

Learning Climate Survey: Quarterly

This survey is completed anonymously. Responses are seen by the training director and assistant training director and are discussed as needed with the training faculty.

1. To what extent have training faculty modeled openness and respect for differences in race, sex, sexual orientation, religion and age?

2. To what extent have training faculty treated you with respect and shown concern for your growth as a clinician?

3. To what extent have you seen training faculty modeling appropriate professional behavior with patients?

4. Have you had any experiences in which you have felt treated unfairly by training faculty?

   If so, please comment:

5. How do you feel your training cohort is getting along?

6. If there are problems in the training cohort, is there anything the training faculty can do to assist in resolving these problems?

7. Please let us know anything else that you think would be helpful.

Appendix W

End of Year Learning Climate Survey

Learning Climate Survey Faculty Attitudes: Biopsychosocial Factors

1. Training faculty modeled respectful attitudes toward women.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty.....Always
Comments:

2. Training faculty modeled respectful attitudes toward racial/ethnic minorities.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

3. Training faculty modeled respectful attitudes toward biopsychosocial variable.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

4. Training faculty modeled respectful attitudes toward people with mental or physical disabilities.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

5. Training faculty modeled respectful attitudes toward people of differing religious faiths.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

6. Training faculty modeled respectful attitudes toward people of varying ages/generations. Rarely ……Sometimes/Some faculty ……Often/most faculty ……Always Comments:

Faculty attitudes: Science/Evidence-based practice

1. Training faculty modeled keeping up with current research in the field.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

2. Training faculty encouraged the use of evidence-based practice.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

Faculty Behavior: Supervision

1. Training faculty treated me with respect.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

2. Training faculty encouraged me to express my opinions.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

3. Training faculty appeared to care about my professional development.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

4. Training faculty appeared to care about my personal development.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

5. Training faculty maintained appropriate boundaries in supervision.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

Faculty Behavior: As clinicians

1. Training faculty modeled professional behavior with patients.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

2. Training faculty appeared compassionate and motivated to help patients in distress.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

3. Training faculty appeared to monitor their own responses to patients and to recognize when these responses represented countertransference.

Rarely ……Sometimes/Some faculty ……Often/most faculty……Always

Comments:

4. Training faculty modeled appropriate boundaries with patients.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

Faculty Behavior: Collegial

1. Training faculty sought peer consultation for difficult cases.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

2. Training faculty appeared to work well together as a group.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

3. Training faculty appeared to interact with each other respectfully.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

4. Training faculty modeled supportive attitudes towards other faculty members who were having personal or professional problems.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

5. Training faculty modeled supportive attitudes towards trainees who were having personal or professional problems.

Rarely ……..Sometimes/Some faculty ……..Often/most faculty ..... Always
Comments:

Please use the space below to comment on any other experiences in your training year that you feel are relevant to the areas addressed above or that you feel most comfortable sharing in an anonymous format.