Navy Medicine Readiness and Training Command

Naval Medical Center Portsmouth
Psychology Internship
Training Manual

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PSYCHOLOGY TRAINING PROGRAMS

CLINICAL PSYCHOLOGY INTERNSHIP TRAINING PROGRAM

PROGRAM MANUAL

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PREFACE

This training manual provides a detailed description of the Navy Clinical Psychology Internship Training Program at the Naval Medical Center Portsmouth (NMCP), VA. The NMCP Psychology Internship Training Program is one of three Navy Clinical Psychology Internships. The other Navy Internship sites are located at the Naval Medical Center San Diego (NMCSD), CA, and Walter Reed National Military Medical Center (WRNMMC), Bethesda, MD. The internship programs at WRNMMC and NMCSD participate in the Association of Psychology Postdoctoral and Internship Centers (APPIC) Match. The NMCP program does not participate in the APPIC Match. NMCP is partially affiliated with the Department of Medical and Clinical Psychology of the Uniformed Services University of the Health Sciences (USUHS), Bethesda, Maryland, and accepts applications from this program on a yearly basis. Other applicants to the NMCP program are limited to persons whose graduate studies have been financially supported by the Navy Psychology Health Professional Scholarship Program (HPSP). Although the three Navy Internship Programs are similar in mission and structure, and work in cooperation with one another, the sites do not function as a formal Consortium as defined by the American Psychological Association.

The terms NMCP and Navy Medicine Readiness and Training Command, Portsmouth (NMRTC-P) will be used as appropriate throughout this training manual. NMCP and the Navy Medicine Readiness and Training Command Portsmouth (NMRTC Portsmouth) are closely connected but serve distinct roles. NMCP's function is the actual hospital—providing direct medical care to active-duty personnel, retirees, and other beneficiaries. The mission of NMCP is to perform clinical operations—diagnosis, treatment, surgery, inpatient and outpatient services. NMCP is the healthcare delivery side of the organization. NMRTC-P is the command that oversees the training, readiness, and operational deployment of medical personnel. NMRTC-P's mission is to ensure medical staff are ready to deploy with the fleet and other operational units. NMRTC is the military and training side of the medical operation.

The NMCP Clinical Psychology Internship Training Program is housed within the Mental Health Department at NMCP. The program provides an intensive twelve-month in-service period of clinical and didactic experiences. Interns develop a wide range of professional competencies within the context of four training rotations (Inpatient/Acute Care, two in outpatient mental health, and an elective tract with a choice among health psychology, child/family psychology, or neuropsychology assessment). The interns also participate in a year-long Transrotational Evidence Based Therapy learning experience and receive an introduction to substance use disorder treatment within a Navy dual diagnosis residential treatment facility. The mission of the program is the development of generalist clinicians who emerge from the training program with foundational and functional competencies appropriate for entry into a generalist clinical practice. Graduates of the program are expected to embark on a path of life-long learning to assure ongoing development of professional skills.

The unique aspect of the training experience is the additional development of skills that will allow for the practice of clinical psychology in a military setting. Interns may spend time aboard a major Navy combatant vessel working with the ship's psychologist, visit a Marine or Navy SEAL base where other psychologists practice, or work alongside psychologists who are part of the Fleet Surgical Team, providing services directly to the operational units. The training year, combined with competencies developed through prior practicum experiences, provides the foundation needed for practice within the military mental health system, yet is sufficiently broad to prepare the intern for practice in diverse non-military clinical settings. Furthermore, this program prepares the interns for eventual licensure as a psychologist in the state of his/her choosing, and is conducive to eventual attainment of Board Certification in clinical psychology.

This program is partially affiliated with the Department of Medical and Clinical Psychology of the Uniformed Services University of the Health Sciences (USUHS), Bethesda, Maryland, and accepts applications from this

program on a yearly basis. Other applicants are limited to persons whose graduate studies have been financially supported by the Navy Psychology Health Professional Scholarship Program.

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

Office of Program Consultation and Accreditation

American Psychological Association

750 First Street, N.E.

Washington, D.C., 20002-4242

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NAVY PSYCHOLOGY TRAINING AND PRACTICE

Most Navy psychology interns have had no prior military experience and will attend the five week Officer Development School (ODS) at Newport, Rhode Island prior to arrival at an internship site. There may be exceptions for ODS requirements for incoming interns who have had certain prior military experience; this determination is made by Navy Personnel Office. ODS is designed to provide newly commissioned Navy officers with the basic information required to understand Naval culture. ODS training includes didactic presentations on the history, traditions, and organization of the Navy. Instruction is designed to provide new officers with the knowledge and skills necessary for professional conduct in the United States Navy. There is also a physical training focus which includes weekly "mock" Physical Readiness Tests (PRT) and an official Navy PRT.

We have learned from former interns that graduates of Navy internships typically report to a professional assignment that demands a higher level of independent responsibility and professionalism than his/her peers in civilian practice. Our teaching faculty has identified, and continues to develop, learning experiences aimed at imparting the skills necessary for effective professional performance at the interns' first assignment as a Navy psychologist. These experiences are organized into a dynamic curriculum which embodies the principles set forth in the current Standards of Accreditation (SoA) of the American Psychological Association (APA).

There are a number of ways in which the generic professional skills imparted through the internship can be operationally described. A useful model which we have attempted to follow is to define the skills as a set of profession-wide and program-specific competencies. The Navy Clinical Psychology Internship Program has adopted the profession-wide competencies outlined in APA's SoA (2015) to include the following competencies: research; ethical and legal standards; individual and cultural diversity; professional values, attitudes, and behaviors; communication and interpersonal skills; assessment; intervention; supervision; and consultation. The program also emphasizes the development of the program-specific competencies of Teaching and Officer Development.

The clinical experiences reflect the major areas in which Navy clinical psychologists may provide clinical services: adult outpatient behavioral health, health psychology, child and family psychology, inpatient assessment and intervention, substance abuse and rehabilitation, and neuropsychological assessment. The program-specific competencies can be found in Appendix A. Operational training trips enable the intern to experience professional activities, patient populations and service environments consistent with the work of a Navy psychologist. The trans-rotation experience offers longer-term practice of psychotherapy across the entire 12 months of training.

Following the internship, graduates are assigned to Navy medical centers or medium sized hospitals where they continue to practice under supervision until they attain licensure in one of the fifty states or the District of Columbia. At that point, they are able to be credentialed as a Licensed Independent Provider by the commanding officer of the medical facility to which they are assigned. All internship graduates are expected to achieve state licensure within 18 months of internship graduation. Ultimately, we encourage our graduates to earn Board Certification from the American Boards of Professional Psychology.

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, Airforce, 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 330 million-dollar, 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 located 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 Airforce medical facility at Langley Airforce Base.

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 support 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.

Another primary mission of NMCP is teaching. NMCP hosts a medical transitional year physician internship program, 15 accredited medical residency and fellowship programs, with over 250 physicians in training, and the 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. 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. As part of its commitment to health care education, the psychology internship training program has the full financial support of the Department of the Navy.

NMCP is 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. The DMH has recently established the Warrior Concussion Clinic to advance the clinical care, diagnosis, research and education of military service members with traumatic brain injuries (TBI) and psychological health (PH) conditions.

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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 for psychologists and social workers. 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. 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 interns spend most of the training year there. There is also mental health assets located in the BHCs throughout the surrounding geographical area in reasonable proximity to the main medical center where interns may be afforded training opportunities. The DMH has appropriate offices/workspaces for interns, 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 Internship Program combines clinical service training and scholarly inquiry to prepare diverse psychology interns for a career of life-long learning, and to function as effective and ethical generalist psychologists in a wide range of settings and sociocultural diverse patient populations Training competencies are consistent with American Psychological Associate (APA) Standards of Accreditation Graduates of the program will be equipped to secure professional licensure as psychologists and to transition successfully to employment as a US Navy Officer and Navy psychologist.

The aims of the internship training program are as follows:

1.) Develop professional competency at the developmental level of readiness for entry to practice through the integration of evidenced based practice and research

2.) Facilitate the transition of an intern from student, to a broadly trained autonomous and responsible practicing generalist psychologist, who can effectively contribute to an interdisciplinary team.

3. Equip the intern with additional knowledge and skills needed to practice competently within the Navy/military environment (e.g., unique military populations, personnel evaluation skills, and fitness for duty evaluations).

Within the constructs of these overarching aims, every aspect of our training model is informed by the notion of professional competence and is designed to develop competent "generalist" psychologists capable of functioning in diverse treatment settings. Interns complete four 12-week training rotations (two rotations in outpatient mental health, one inpatient/emergency psychiatry rotation, and an elective choice among health psychology, child/family psychology, and neuropsychology). Additionally, interns participate in a year-long Transrotational learning experience. Training in providing consultation to commands (e.g. consults to client/patient employers) and consultation with other medical and mental health disciplines is emphasized across rotations throughout the training year. In addition, there is an introductory exposure 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. The interns will develop a clinical skill set that 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.

Training objectives and assessments of intern performance throughout the training year and at its conclusion are delineated according to specific competency benchmarks. The program has committed to the transition from the Guidelines and Principles (G&P) to the Standards of Accreditation. In accordance with our aims and in congruence with American Psychological Association, Commission on Accreditation, *Standards of Accreditation in Health Service Psychology*, the psychology internship program at NMCP's assessed competencies include the following: Research, Ethical and legal standards; Individual and Cultural Diversity; Professional values, attitudes, and behaviors; Communication and interpersonal skills; Assessment; Intervention; Supervision; and Consultation and interprofessional/interdisciplinary skills
In addition, the training program provides training opportunities and assesses interns within the program specific competencies of Teaching and Officer Development.

Competency Benchmarks used in this program were originally developed 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*, and our assessment instruments parallel those recommended in the accompanying article, *Competency Assessment Toolkit for Professional Psychology* (Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfo, 2009). As the program has grown and evolved, we have continually updated our Competency Benchmarks, centered on program aims and guided by relevant literature and APA resources. We have found that these published resources offer our training program the best available guidance regarding the conceptualization and assessment of competence for the emerging psychological provider: Hatcher, Fouad; Grus, Campbell, McCutcheon, Leahy, Kerry L., & May 2013. *Competency benchmarks: Practical steps toward a culture of competence.* Training and Education in Professional Psychology, Vol 7(2), 84-91; Price, Callahan, Cox, (2016). *Psychometric Investigation of Competency Benchmarks*. Training and Education in Professional Psychology, and http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx/.

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

levels and to make them more reflective of fine-grained developmental changes, we have made the assumption that developmental stages are continuous and can be subdivided into intermediate levels separating the major stages.

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

1.00 Meets criteria for Readiness for Practicum

1.25 Mildly exceeds some criteria for Readiness for Practicum

1.50 Mid-way between Readiness for Practicum and Readiness for Internship

1.75 Approaches or meets some criteria for Readiness for Internship

2.0 Meets criteria for Readiness for Internship

2.25 Mildly exceeds some criteria for Readiness for Internship

2.50 Mid-way between Readiness for Internship and Readiness for Entry to Practice

2.75 Approaches or meets some criteria for Readiness for Entry to Practice

3.00 Meets criteria for Readiness for Entry to Practice

3.25 Mildly exceeds some criteria for Readiness for Entry to Practice

3.50 Mid-way between Readiness for Entry to Practice and Readiness for Entry to Fully Autonomous Practice

3.75 Approaches or meets some criteria for Readiness for Entry to Fully Autonomous Practice

4.00 Meets criteria for Readiness for Fully Autonomous Practice

4.25 Mildly exceeds some criteria for Readiness for Fully Autonomous Practice

4.50 Mid-way between Readiness for Fully Autonomous Practice and Readiness for Life-long Learning

4.75 Approaches or meets some criteria for Readiness for Entry to Life-long Learning

5.00 Meets criteria for Entry to Life-long Learning/Master Clinician

It is important to note that assignment of developmental levels per the above numerical scale is based on supervisor judgment. We are not implying that this is a psychometrically precise measurement scale. Supervisors must compare the descriptively anchored, benchmarked standards against data obtained through direct observation of trainee activities, informed by other data sources (e.g., ratings made by interdisciplinary team members, outcome data for patients seen by trainees, objective tests covering reading assignments, review of audio/video tapes of clinical activities), and render a developmentally anchored conclusion regarding trainee competence. Analyses regarding inter-rater agreement among supervisors has been consistent with findings indicating that a minimum of two raters are needed to obtain reasonably reliable ratings of competency domains.

Findings also indicate that inter-rater reliability is mildly enhanced by a third rater, but there is very little value to having more than three supervisors participate in the rating process.

Interns must demonstrate competence in:

Required Profession-Wide Competencies

1. Research

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

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

2. Ethical and legal standards

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

3. Individual and cultural diversity

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

4. Professional values, attitudes, and behaviors

Professionalism—The intern will: 1.) demonstrate the ability to continually monitor and independently resolve situations that challenge professional values and integrity; 2) consistently conduct self in a professional manner across all settings; 3.) independently accept personal responsibility across settings and contexts; 4.) independently act to safeguard the welfare of others; and 5.) demonstrate a consolidation of professional identity as a psychologist exhibited by being knowledgeable about issues central to the field and demonstrating evidence of integration of science and practice.

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

5. Communication and interpersonal skills

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

6. Assessment

Assessment—The intern will: 1.) independently select and implement multiple methods and means of evaluation in ways that are responsive to and respectful of diverse individuals, couples, families and groups and context; 2.) independently understand the strengths and limitations of diagnostic approaches and interpretation of results from multiple measures for diagnosis and treatment planning; 3.) independently select and administer a variety of assessment tools and integrate results to accurately evaluate presenting question appropriate to the practice site and broad area of practice; 4.) utilizes case formulation and diagnosis for intervention planning in the context of stages of human development; 5.) independently and accurately conceptualize the multiple dimensions of the case based on the results of assessment; 6.) communicate results in written and verbal form clearly, constructively, and accurately in a conceptually appropriate manner.

7. Intervention

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

8. Supervision

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

9. Consultation and interprofessional/interdisciplinary skills

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

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

Required Program-Specific Competencies

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

2. **Officer Development**—The intern will: 1.) exhibit basic military knowledge and officership (i.e. criteria beyond professionalism as it pertains to being a uniformed services officer); 2. Demonstrate career commitment as a Navy Psychologist.

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

Expected Average* Performance Targets Per Rotation Sequence

Rotation Sequence

	1st	2nd	3rd	4th
Competencies	2.25 (1.75, 2.00) **	2.50 (2.00, 2.25)	2.75 (2.25, 2.50)	3.00

* Averages are based on ratings made by each intern's rotation supervisor and transrotational supervisor. The rating process is explained further below.

** The first number in parentheses specifies the lowest acceptable average rating for an individual competency domain and the second number specifies the lowest acceptable average rating across all the competencies. Note that for the 4th quarter ratings, the lowest acceptable average rating is 3.0, Readiness for Independent Practice. We recognize that throughout the training year, some competency domains may progress at different rates and

therefore allow some flexibility in the lowest acceptable average ratings. However, we expect that by the end of the training year, all interns will be ready for independent practice.

NMCP PSYCHOLOGY COMPETENCY ASSESSMENT TOOLKIT

The Competency Assessment Toolkit is a multifaceted approach to competency assessment that is incorporated in this program. As noted above, assessments are completed at the end of each of four clinical rotations, and the assessment conducted after the fourth and final rotation represents the intern's summative competency determination for the training year. Ratings are made by the intern's direct clinical supervisors (i.e., rotation supervisor/supervisors and the transrotational supervisor), who form the Competency Committee for each trainee. Competency Committees will be composed of two to three supervisors. A third supervisor will be asked to rate the intern in the following circumstances:

1. When the intern's averaged ratings by the primary and transrotational supervisor fall below the lowest acceptable average rating for that point in the training year (as defined above)
2. When an intern is on a remedial status (meaning that the ratings for that quarter will determine whether the remediation is lifted).

The ***Competency Assessment Rating Scale*** is our primary tool for assessing intern competency. Using the numerical system described above (e.g., 3.00 represents readiness for entry to practice) and referencing the **Competency Benchmarks** document, supervisors use information obtained from direct observation plus findings from instruments/procedures described below to assign a developmental level to each of competency domains, based upon the training objectives. All ratings are made independently. Average ratings are calculated and judged relative to the performance expectations as specified in the table above. (See Appendix A, page 33 of this manual, for a copy of the Competency Assessment Rating Scale).

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

Work Samples: During the last two weeks of each training rotation, the primary supervisor and transrotational supervisor will review a minimum of one video tape of the intern performing a diagnostic interview and a minimum of one video tape of a therapy session. Additionally, the supervisors will complete a multi-itemed rating scale assessing various aspects of the taped clinical performances (see Appendix C, page 64 of this manual for the Work Samples Rating Scale). These ratings are available to the intern for inspection at the end of the rotation. Supervisors also review the FIRST DRAFT (e.g. unedited) written documentation for the diagnostic interview. Additionally, the progress note's FIRST DRAFT (e.g. unedited) linked to the therapy session, and two additional progress notes FIRST DRAFTS (e.g. unedited) for the same patient are evaluated. Interns will obtain appropriate informed consent from each patient prior to securing videotaped materials. The inpatient supervisor will observe the intern conduct a diagnostic interview on the ward in a treatment team setting and will read a diagnostic interview from the intern's ER rotation. Rather than listening to a therapy session and reading accompanying progress notes, the inpatient supervisor will observe the intern conduct an inpatient process group and will rate the group using the Psychiatry Inpatient Process Group Evaluation Tool. (See Appendix D, page 80 of this manual for this scale).

End of Rotation Case Presentation: During the last week of the second and fourth rotation, interns will present a case to an audience composed of the other interns, their clinical supervisors, and other training committee members. In preparation for the case presentation, the intern will perform a focused literature review addressing an issue related to the case. Findings from this literature search will be used to inform the case presentation in a manner that demonstrates the intern's ability to engage in, and apply, scholarly activity. Additionally, during the case presentation the intern must address at least one ethical issue and comment on indications for consultation and advocacy. In addition, the intern must discuss the role of outcome measurement to the case or provide evidence of knowledge regarding outcome assessment in the event that the case of interest did not receive psychological interventions (e.g., a case that emphasizes assessment rather than treatment). The case presentation will be evaluated by supervisors with the Case Presentation Rating Scale (See Appendix F for a copy of this rating scale) and by intern peers (see Appendix G, for a copy of the Peer Perception Survey).

Grand Rounds Presentations: Interns may have the opportunity to present at least once at the weekly Mental Health Grand Rounds. These will be one-hour presentations on a topic of the intern's choice; examples would include a presentation of dissertation data, a clinical case with relevant research, or a research review of a topic of interest. Interns may choose to share a presentation, for example, a shared literature review. The interns' presentation will be rated by two training faculty members using the Grand Rounds Presentation Rating Form (See Appendix H).

360-Degree-like "Customer" Perception Surveys: Four brief survey instruments are administered during the last month of each rotation by the training administrative assistant. Surveys are administered as structured interviews to three patients, two referral sources or two interdisciplinary team members (or one of each at the discretion of the rotation supervisor), and two support personnel. (See Appendices I-L, for these instruments).

Peer Supervision Skills Rating Form: Once per quarter, interns engage in peer supervision sessions under the guidance of their Transrotational supervisor. A video tape of the supervision sessions will be made for review by their transrotational supervisors. A rating scale addressing the quality of supervision will be completed by the supervised peer immediately after the supervision session and will be completed by the supervisor prior to the end of the quarter. (See Appendix N for this form.)

Navy Fitness Report: In addition to the assessment of psychological competencies, as outlined above, all Navy officers receive annual Fitness Reports, an evaluation of their performance both in their areas of specialization (i.e., the practice of clinical psychology) and, more generally, regarding their leadership abilities, team work, and capabilities as an officer. The Fitness Report is prepared by the Training Director and reviewed by the Psychology Chair and Director for Mental Health before being forwarded to the Commanding Officer for final edits and signature. (See Appendix DD for this form.)

TRAINING PROGRAM ELEMENTS

Overview: Upon entering the program, interns complete an orientation period and then are assigned to one of four clinical rotations. Additionally, they are assigned a supervisor from among the available training staff to serve as their Transrotational Therapy supervisor. Major rotations are in the Adult Mental Health Clinic (2), Inpatient/Emergency Services, and Health Psychology, Child/Family Psychology, or Neuropsychology. Prior to the start of the program, interns will have been asked to indicate their preferences for either the child/family, health, or neuropsychology rotations, and an effort will have been made to give them a preferred choice.

Rotations are approximately 3 months in length. Interns also participate in weekly didactic trainings plus a variety of other training activities. Specific descriptions of these training elements are offered below:

Orientation: The intern initially spends approximately 14 days completing hospital-wide mandated trainings (e.g., HIPPA training, Command Orientation, computerized medical record training) and attending didactics in ethics, biopsychosocial variables, and psychological practice in the Navy. During this period the intern completes the first entries into his/her self-study.

Intern Lunch: The training program has set aside one hour per week for the interns to gather and eat lunch together in a reserved conference room (when permitted by hospital COVID-19 policy). No patients or supervisions are to be scheduled during this time.

TRAINING ROTATIONS

The program is organized around three training environments divided into four primary rotations lasting approximately three months each—two rotations are spent in the outpatient training setting. Additionally, the intern participates in the Transrotational Learning Experience over the course of the entire training year. Expectations for each rotation are detailed in a **Supervision Contract**, which is signed by the supervisor and the intern. Interns are evaluated on each of the training competencies, described earlier in this document, at the end of each rotation. We do not have specific competencies assigned to individual rotations, as we view professional competencies as qualities that are expressed in a manner that is largely independent of situational contexts. We acknowledge that some rotations lend themselves more to the development of some competencies than do others (e.g., the neuropsychology rotation offers the widest array of assessment-related learning experiences, and the inpatient rotation exists within the richest interdisciplinary milieu), yet over the course of the training year each intern is afforded appropriate training experiences to meet end-of-year competency targets. Additionally, since all competencies are addressed in each rotation, poor performance on the part of an intern will not result in repeating the rotation. Rather, as described later in this document, the intern will be placed in a remedial status for the next rotation and will be provided with a written plan designed to remediate detected weaknesses in competency development. See page 25 of this manual for a complete description of this process.

In 2017, the training committee decided to pilot including individualized goals in supervision contracts in order to increase the emphasis in supervision on attending to trainees' individual professional needs. Supervision contracts will now include specific individualized training goals that the interns and supervisors generate together through discussion. Interns 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.

General descriptions of the rotations are as follows:

Outpatient Mental Health: The Outpatient Mental Health rotation is provided through the Mental Health Department at Naval Medical Center Portsmouth. Interns complete two consecutive, three-month rotations. One rotation is spent entirely at the NMCP Outpatient Mental Health Clinic. In the other rotation, interns may have the opportunity to spend at least one day per week working with one of our faculty members who is an embedded psychologist (i.e., psychologists attached directly to operational units such as aircraft carriers) or at a branch clinic that serves a specific local base (Sewell's Point Clinic, Boone Outpatient Clinic,

Oceana Outpatient Clinic, Little Creek Outpatient Clinic). Opportunities for branch clinic and operational experiences are arranged based on the interest, developmental level, and experience of the intern and the availability of embedded psychologists. These experiences may vary for individual interns. A wide assortment of clinical problems is addressed within these clinical arenas, including mood, anxiety, adjustment, and psychotic disorders plus relational and occupational problems. Interns will engage in assessment services incorporating diagnostic interviewing, and when indicated, psychological testing. They will also provide individual and (at times) group psychotherapy, with an emphasis on evidence-based intervention approaches. Additionally, in both settings exposure to interdisciplinary care activities will be provided. The incorporation of branch medical clinics exposes the trainee to a full range of acute and chronic outpatient clinical presentations and provides more in-depth exposure to issues particular to specific populations (for example, aviation). See Appendix for a Copy of the Outpatient Supervision Contract.

Inpatient/Emergency Services Rotation: Training will occur primarily on the Inpatient Psychiatric Unit, Building 2 of NMCP and in the NMCP Emergency Room. The Inpatient Psychiatric Unit provides three treatment tracks: for dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus a psychiatric disorder); for patients with psychotic disorders; and for patients with primary mood, adjustment or personality disorders. The unit serves both active duty and adult family members. The intern will attend and participate in morning rounds, interview new patients, develop/monitor treatment/discharge plans, provide individual therapy/crisis intervention, lead daily process groups, and interpret psychological testing as needed. Interns are expected to meet with patients on a 1:1 basis, as deemed necessary by the treatment team, for individual therapy while that patient is on the unit. The intern will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated services to patients. The intern will also consult with family members and with the commands of active-duty service members to make decisions regarding military disposition. At various points during this rotation, the intern will be "on call" with psychiatric residents for emergency room psychiatric consultations or for the Consult/Liaison services that provide consultation to the medical wards. See Appendix P for a copy of the Inpatient/Emergency Services Rotation Supervision Contract.

Substance Use Disorders Rotation: For this rotation the intern will be assigned to the Substance Abuse Rehabilitation Program (SARP) located at Naval Medical Center Portsmouth. Supervision is provided by a licensed psychologist assigned to that program. SARP is an 80-bed substance abuse treatment facility that provides a full range of treatment services to active-duty military personnel. The intern will be oriented to the field of substance abuse treatment and will develop skills necessary to provide substance abuse treatment to adult clients. Initially, interns participate in a set of orientation activities offered at SARP and subsequently participate in a broad range of professional services including substance abuse assessment, treatment planning, interdisciplinary team meetings, individual therapy, and group therapy. Interns are also exposed to the nonclinical roles subsumed by psychologists within this treatment environment. Specifically, they gain experience in the areas of addictions counselor training, and are exposed to peer review processes, process improvement activities, and business plan meetings. See Appendix Q for a copy of the Substance Use Disorders Rotation Supervision Contract.

Health Psychology Rotation: The Health Psychology rotation is anchored in the Outpatient Mental Health Clinic. 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 and acceptance and commitment group and individual therapy for chronic pain. The intern will gain exposure to instruments used to assess emotional and behavioral components of chronic pain. The intern will have the opportunity to consult with physical therapists, physiatrists, surgeons, and anesthesiologists and to observe pain management procedures. The intern will also conduct short-term group Brief Behavioral Treatment for Insomnia for patients referred form the Sleep Medicine Clinic. Health Psychology interns also help to conduct mindfulness groups for

special forces patients enrolled in an intensive TBI assessment and treatment program. See Appendix R for a copy of the Health Psychology Supervision Contract.

Child/Family Rotation: This rotation takes place in the Child Mental Health Clinic. The rotation prepares the intern to provide assessment, intervention and consultation with families of active duty service members. Interns will develop skills in the areas of intake processing, psychological evaluation/assessment, individual, group and/or family therapy, and in consultation with primary medical care providers, commands and local school districts. The rotation emphasizes responding to the unique challenges military families face. Groups provided in this clinic have include anger management, anxiety, parenting skills, trans-affirmative therapy, and DBT for adolescents. Other opportunities for familiarization and consultation with other military and local community child and family resources are provided as appropriate. Interns may receive exposure to Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for disruptive behavior and attachment problems in preschool-age children. The intern will primarily be supervised by a child psychologist but will also have the opportunity to work with psychiatrists and licensed clinical social work staff. See Appendix S for a copy of the Child/Family Supervision Contract.

Neuropsychology Rotation: The neuropsychology rotation takes place in the Neuropsychology and Interdisciplinary TBI clinics. Interns in the neuropsychology rotation will assist in performing assessments of patients referred for neuropsychological evaluation for traumatic brain injury (TBI) as well as a variety of other medical conditions that affect cognitive processes. The intern, under supervision, will have an opportunity to learn the neuropsychological clinical interview, and administration, scoring and interpretation of neuropsychological tests. The interns will discuss results with the supervisor and may participate in feedback sessions with the patient (under supervision) and referral sources. The intern will participate in interdisciplinary committees on an ad hoc basis. The intern may also have the opportunity to shadow a neurologist at Naval Medical Center Portsmouth to learn more about medical assessment and treatment of neurological conditions. The intern's training rotation will be four-tiered:

- Neuropsychological clinical interview
- Test administration, scoring and interpretation
- Report writing
- Clinical feedback

See Appendix T for a copy of the Neuropsychology Rotation Supervision Contract.

Transrotational Therapy Experience: Interns are assigned a Transrotational supervisor at the beginning of the training year and are expected to always carry two to three patients. The interns and their supervisors will collaboratively use the intern's individualized training goals to determine the types of patients, presenting problems, and therapy modalities that comprise this experience. During each quarter of the training year, the Transrotational supervisor provides supervision of the intern's peer supervision activities. See Appendix U for a copy of the Transrotational Supervision Contract.

Supervision: Interns will receive a minimum of four hours of supervision each week. At least two of these hours will be individual supervision provided by a licensed psychologist who is part of our training faculty and has clinical responsibility for the intern's cases being supervised. The remaining two hours will be provided in either an individual or group format and may be provided by a licensed psychologist or a licensed practitioner in

a related discipline, e.g., a psychiatrist. Interns can also expect significant amounts of unscheduled supervision between scheduled supervision appointments. A licensed clinician is available immediately for all emergency situations that arise. Interns submit forms each week documenting supervision hours; these forms are reviewed and signed by supervisors (see Appendix W, page 162). These forms also document various aspects of the week's supervision, such as audio/video recordings of clinical work, supervisors provided direct feedback to interns, and any issues in the supervisor-supervisee relationship were addressed. Additionally, interns are required to summarize the relative emphasis of the week's supervision efforts from the perspective of competencies that form the basis of our competency determinations. This information is entered into a data base by the Training Administrative Assistant and may be accessed by interns and supervisors by request. Submission of supervision forms also provides a means of ensuring that the minimum supervision hours have been met for each training week. The Administrative Assistant scrutinizes the training hours submitted each week and if the minimum requirement has not been met, the Training Director and the intern's rotation supervisors are promptly informed. The rotation supervisors then establish a plan for making-up the missed hours and the Administrative Assistant collects documentation attesting to the success of this plan.

All outpatient interns attend 2 hours per week of group supervision with post-doctoral fellows, the training director or assistant training director, and at least one other training faculty member. During group supervision, one intern or fellow presents a challenging case, including a portion of videotape, and receives feedback from peers and faculty. They are expected to incorporate a discussion of biopsychosocial variables into this case discussion. Interns also participate in peer supervision once per quarter (one hour as supervisor and one hour as supervisee). These peer supervision sessions are recorded and rated by both the supervisee and the transrotational supervisor. All outpatient interns also attend Lunch and Learn seminars once per week with post-doctoral fellows, the training director or assistant training director, and at least one other training faculty member. These seminars involve group discussion of a reading relate to biopsychosocial variables or ethics selected and presented by an intern or fellow.

Reading Assignments: Interns will have recommended reading for each quarter of the training year. Readings are chosen to cover each of the competency domains addressed by our training model. An updated reading list is provided each year. A few of the reading assignments are linked to specific didactic presentations and the intern must read these prior to the didactic. See Appendix E of this manual, for a list of topic that will be covered in assigned readings.

Didactics: Interns receive two hours of didactic training most weeks, and several didactic offerings are full-day or longer training experiences.

The full-day or longer presentations will include the below at a minimum and may include other full-day didactics if they become available and are consistent with the program's training goals:

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

Prolonged Exposure Therapy and Cognitive Processing Therapy: Two 2-day workshops presented by the Center for Deployment Psychology that prepare interns to conduct these evidence-based therapies for Post-Traumatic Stress Disorder.

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

Embedded Experiences: 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. Interns 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, train with and observe SEAL Team psychologists; 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. Embedded experiences will be based on the timing of available opportunities within the various embedded environments, as well as interns' prior training and interests. Interns' experiences and opportunities may vary.

Officer of the Day: Interns will serve as Officer of the Day on a rotating basis. In this capacity, the intern serves as the point person/first line for all the codes, facilities, and concerns that happen within the hospital for that day. They work with the Chief of the Day, Command Duty Officer, Nurse of the Day, and Director and Assistant Director for Administration to ensure an efficient response is given to any hospital issues that occur, and to also communicate pressing matters to the XO and CO for awareness.

DYNAMIC TRAINING ENVIRONMENT

It is important to note that the Navy operational and training environment is very dynamic. Thus, we often adjust our training activities to meet changing organizational and training demands and opportunities. Usually these changes enhance our program; but at times mission demands may require the program to alter training schedules, reduce certain training components or remove specific minor components of the training program. Such changes would not affect the major components of the program.

PREPARING INTERNS TO SERVE A DIVERSE MILITARY

A goal of our training program is to foster the ability of our interns to provide competent care to service members and their families (and to the public once the intern leaves Active Duty service) , and interns' competencies in professional practice are evaluated regularly. Some interns 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 interns in the process of developing competencies to work with diverse populations. Supervisors respect the right of interns 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 interns 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 interns 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 interns to beneficially navigate value- or belief-related tensions. At times, we will consider patient re-assignment, so interns have time to work to develop their

competence to work with patients who challenge interns' 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 interns' 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, interns 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 interns. The faculty recognizes its duty to provide special assistance to interns who are having difficulty learning. When an intern is determined to be making insufficient progress, faculty supervisors and the intern involved will cooperatively attempt to find the reasons for the difficulties 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 EE). Serious disciplinary infractions will be handled through the NMCP chain of command (e.g. the Director for DMH, and the NMRTC 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.

Interns 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 graduate from internship, all training elements must be satisfactorily completed with a rating at or above the 3.0 level. In the event that 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 intern 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 an intern is determined to be making insufficient progress, faculty supervisors and the intern involved will cooperatively attempt to find the reasons for the difficulties 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 Training Committee during regularly scheduled Training Committee meetings. This first step is an informal process and does not result in placement of the intern into a remedial or probationary status.

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

1) Are rated below the lowest acceptable average for an individual competency domain.
   OR
2) Receive an overall average rating across all competency domains that falls below the value set as the lowest acceptable average rating.
   OR
3) Are rated below the 3.0 (Readiness for Independent Practice) level for any competency domain or for the average across all competency domains at the end of the training year.

If one of the above criteria is met, the intern can be placed on Departmental Remediation and a specific, written, remediation plan is developed by his/her supervisors, along with the training director and assistant training director. 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 intern and members of the Competency Committee sign this plan. This is considered departmental 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 intern 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 is followed. If the GMEDC determines that command probation, suspension, remediation, or probation is warranted, the intern'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 internship. It is also possible that an intern 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 Commander. The intern's rights to due process protections are maintained throughout all actions initiated for deficient performance. Interns are entitled to representation by a Navy legal officer (attorney), free of charge.

An intern 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 intern's periodic military fitness report.

GMEDC APPEAL PROCESSES

Any intern who has received formal written notification from the Chairperson of the GMEC 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. Interns 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 Internship 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. Discrimination on the basis of a person's race, color, nation of origin, sex, age, or disability fundamentally violates these essential core values of respect and dignity. Discrimination demeans any work environment and degrades the good order and discipline of the military service. It is policy that all members of this command will conduct themselves in a manner that is free from unlawful discrimination. Equal opportunity and treatment will be provided for all personnel. 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. Interns 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 intern should first attempt to resolve any complaint at the lowest level possible. Even if the intern can resolve the situation without assistance from a supervisor, the intern 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 intern 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 intern should speak to the supervisor about concerns regarding the supervisor's conduct or expectations. If these discussions do not lead to a mutually acceptable solution, the intern should bring the complaint to the Psychology Training Director. The Director will make every effort to hear both sides and determine the most appropriate resolution to the concern/complaint. In general, the Director has only a few possible options available to him/her. He/she may find in favor of the intern and instruct the supervisor in how to modify or correct the situation. He/she may find in favor of the staff member and explain to the intern why the supervisor's behavior is appropriate or acceptable within the training model. Alternatively, the Director might find that clearer understanding between the parties is necessary and can lead to a compromise that will be mutually acceptable and allow the training process to move forward. The Psychology Training Director will hold a meeting with the parties concerned and facilitate such a resolution if the parties so wish. In extreme and unusual cases, the grievance may be so severe as to lead to an investigation and possible dismissal of the supervisor. If an intern 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 intern, the next step in the process would be for the intern 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 interns 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. Interns are informed of the time and place of this meeting. After stating their request to the committee, the intern is excused from the room while committee members debate the issue. The intern is recalled to the meeting when a decision has been reached. If the issue is not resolved to the intern's satisfaction, the above grievance policy may be applied.

PROGRAM EVALUATION BY INTERNS

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

The training committee recognizes the necessity of assessing our "hidden curriculum"; that is, the unacknowledged-- and often unintended--messages that trainees take from their learning environment. In particular, interns learn through observing the emphasis that the program faculty place on issues such as biopsychosocial variables, self-monitoring, and self-care, as well as how program faculty treat supervisees and other faculty members. To assess the degree to which our "hidden curriculum" is congruent with our explicit aims, we provide interns with the opportunity throughout the year to give anonymous feedback via the Quarterly and Final Learning Environment Surveys (see Appendices BB and CC). These surveys were developed collaboratively by the training faculty, interns, and post-doctoral fellows.

POLICY ON VACATION TIME AND SICK LEAVE

The following guidelines have been developed to help staff evaluate requests by psychology interns for time away from the training program. Interns are required to plan their absences, if any, well in advance and to

submit their requests in a manner that will allow adequate review by rotation supervisors, and the Training Director. It is the policy of the program to grant five working days for personal leave/vacation. Interns may also be granted, at the discretion of the Training Director, leave for defense of a dissertation. All requests for absences are contingent upon the projected requirements of the intern's training assignments and upon the intern's progress in the training program. Above all, patient care responsibilities are primary. Consideration of additional time away, such as time for attending graduation ceremonies or in the event of an unusual family emergency, will be on a case-by-case basis, and two extra days of personal leave will be granted to interns who complete dissertations and all other requirements for graduation prior to the end of the internship year.

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

APPLICANT QUALIFICATIONS, APPLICATION PROCESS, AND BENEFITS

This program is partially affiliated with the Department of Medical and Clinical Psychology of the Uniformed Services University of the Health Sciences, Bethesda, Maryland, and accepts applications from this program on a yearly basis. Other applicants are limited to persons whose graduate studies activities, have been financially supported by the Navy at other graduate schools (i.e., have attended graduate school on a Navy scholarship of another Navy-sponsored program). All applicants must come from APA accredited graduate programs and document a minimum of 400 hours of supervised practicum activities (i.e., direct patient contact hours) which include a balance of assessment and treatment experiences with adult clients. The program does not recruit nor accept applicants who are not currently associated with the Navy. Inquiries from such individuals are directed to the Navy's National Training Director so that they may learn of the opportunities afforded by the two Navy internship programs at the Naval Walter Reed National Medical Center in Bethesda, Maryland and the Naval Medical Center, San Diego, both of which participate in the APPIC match procedure. Applicants eligible for our program are not automatically accepted. We have a formal application process that must be followed in order to determine each applicant's readiness and suitability for our program. By 01 September of each year all eligible applicants are emailed a formal application (See Appendix AA for a printed version of the application). Completed applications must be returned via email by 15 October, along with a letter of reference from the graduate school's training director and letters from two clinical supervisors. In the letter from the training director, it must be stated that the applicant is in good standing within the graduate program and that all pre-internship requirements will be met by the time the applicant reports for internship training. An official transcript of graduate studies must also be submitted. Materials should be submitted to the Training Director via encrypted email. Following receipt of this material, an interview with the Training Director will be scheduled, either in person or via telephone (**telephone interviews are sufficient**) in the last week of September. Completed applications plus information gleaned from interviews are reviewed by the Internship Training Committee. Applicants are accepted into the program by majority vote of committee members. Given the small number of eligible applicants, processing of these documents is completed promptly, and notifications of acceptance/rejection are sent to applicants at the beginning of October. This early decision date makes it possible for those who are not accepted for the NMCP internship to apply for internship training at Naval Medical Center, San Diego and Walter Reed National Military Medical Center via the APPIC Match.

All entering interns are commissioned officers in the Navy Medical Service Corps, with most holding the rank of Lieutenant (0-3). Those with previous Navy experience may hold a higher rank. All have completed a 5-

week training program through the Officer Development School (ODS) at Newport, Rhode Island prior to entering our program unless they were already commissioned officers prior to beginning psychology training. Length of obligated military service after completion of the training year depends on the program through which the intern entered the Navy. Health Professions Scholarship Students usually owe 3 years of service, and Uniformed Services University students usually owe 7 years of service. Continued service as a Navy psychologist beyond the internship and years of obligated service is an option. At the end of the internship year, interns will be assigned to serve in one of a variety of positions in support of the mission of the Navy and Marine Corps, including work in stateside clinics or hospitals and overseas service. Interns are expected to complete licensure requirements in the state of their choice within 18 months of completion of this program. Annual compensation can be roughly estimated at https://militarypay.defense.gov/calculators/rmc-calculator/ . Health care expenses are fully covered for all interns and family members, and there are other financial benefits that go along with active-duty service in the Navy, such as access to military exchanges for discounts on food and other goods, life insurance, and free access to legal advice. During the training year interns are provided with appropriate office space equipped with a networked computer and have access to support personnel for assistance with administrative tasks (e.g., opening computerized appointment schedules, booking patients). Additionally, interns have full access to a wide array of psychological testing materials and to the medical center's library facilities, which supports on-line APA journal access from the intern's office computer.

EQUAL OPPORTUNITY POLICY

The Clinical Psychology Internship Training Program operates in accordance with Naval Medical Center Portsmouth's Equal Opportunity Policy

FOR ADDITIONAL INFORMATION

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

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APPENDIX A

COMPETENCY ASSESSMENT RATING SCALE: COMBINED SUPERVISORS

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

Intern: _____ Rotation Supervisor(s): _____

Transrotational Therapy Supervisor: _____

Competency Committee Members: _____
_____
_____

Rotation (circle one): Inpatient Outpatient I Outpatient II Elective: _____

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

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

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

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

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

Averaged* Performance Targets Per Rotation Sequence

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

Performance Expectations:

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

* Averages are based on ratings made by each intern's rotation supervisor and transrotational supervisor, (and one other supervisor at specific times designated by the internship manual) all of whom compose the intern's competency committee.

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

Profession-Wide Competencies

1. Research:

Scientific Knowledge and Methods

Essential Component A: Independently applies scientific methods to practice

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

Essential Component B: Knowledge of core science

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

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

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

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 10 and 16; Peer Perception Survey—items 2, 3 & 9: Grand Rounds Presentation Rating Form—item 1.

_____ Rotation Supervisor's Rating for Scientific Knowledge and Methods

_____ Transrotational Supervisor's Rating for Scientific Knowledge and Methods

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

Research/Evaluation

Essential Component A: Generation of knowledge

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

Essential Component B: Evaluation of outcomes

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

Assessment Methods: Discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 10 & 16; Peer Perception Survey—items 2, 3 & 9.

_____ Rotation Supervisor's Rating for Research/Evaluation

_____ Transrotational Supervisor's Rating for Research/Evaluation

_____ Competency Committee Member's Ratings for Research/Evaluation

2. Ethical Legal Standards and Policy

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—item 11; Peer Perception Survey—item 4.

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

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

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

3. Individual and Cultural Diversity

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

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

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 7 & 12; Work Samples Rating Form—items 10 & 22; Patient Perception Survey—item 4; Peer Perception Survey—item 5; Biopsychosocial and Ethics Consultation Survey—items 1-6; Peer Supervision Rating Scale—items 5 & 10.

_____ Rotation Supervisor's Rating for Individual and Cultural Diversity

_____ Transrotational Supervisor's Rating for Individual and Cultural Diversity

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

4. Professional values, attitudes, and behaviors

Professionalism

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

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

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

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

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; Support Staff Survey—item 2; Patient Perception Survey—items 1,2,3,&7; Interdisciplinary Team Member Survey—items 1,2,& 3; Consultation Services Survey—items 1 & 2; Grand Rounds Presentation Rating Form—Item 6.

_____ Rotation Supervisor's Rating for Professionalism

_____ Transrotational Supervisor's Rating for Professionalism

_____ Competency Committee Member's Ratings for Professionalism

Reflective Practice/Self-Assessment/Self-Care

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study

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

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

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

5. Communication and interpersonal skills

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

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

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

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

Essential Component C: Effective command of language and ideas

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

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; Work Samples Rating Form—items 21 & 24; Support Staff Survey—item 1; Patient Perception Survey—item 8; Peer Perception Survey—item 12; Interdisciplinary Team Member Survey—item 5; Consultation Services Survey—item 5; Peer Supervision Rating Form—items 1 & 8.

_____ Rotation Supervisor's Rating for Communication and Interpersonal Skills

_____ Transrotational Supervisor's Rating for Communication and Interpersonal Skills

_____ Competency Committee Member's Ratings for Communication and Interpersonal Skills

6. Assessment

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

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

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

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

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

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

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; Case Presentation Rating Form—items 1-5; Work Samples Rating Form—items 1-8, 11-15, 17-19; Peer Perception Survey—item 1.

_____ Rotation Supervisor's Rating for Assessment

_____ Transrotational Supervisor's Rating for Assessment

_____ Competency Committee Member's Ratings for Assessment

7. Intervention

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

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

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

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

Essential Component C: Clinical skills and judgment

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study;; Case Presentation Rating Form—item 9; Work Samples Rating Form—items 9, 14,16, 23(a or b); Patient Perception Survey—item 9.

_____ Rotation Supervisor's Rating for Intervention

_____ Transrotational Supervisor's Rating for Intervention

_____ Competency Committee Member's Ratings for Intervention

8. Supervision

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

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

Essential Component B: Knowledge of procedures and practices of supervision

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

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

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

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

Performance Benchmarks: Demonstrates integrity of biopsychosocial 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; Articulates appropriate repertoire of skills and techniques in supervisory process; Identifies impact of aspects of self in therapy and supervision

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

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

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

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

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

_____ Rotation Supervisor's Rating for Supervision

_____ Transrotational Supervisor's Rating for Supervision

_____ Competency Committee Member's Ratings for Supervision

9. Consultation and interprofessional/interdisciplinary skills:

Consultation

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

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

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

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

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

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

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

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

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

_____ Rotation Supervisor's Rating for Consultation

_____ Transrotational Supervisor's Rating for Consultation

_____ Competency Committee Member's Ratings for Consultation

Interdisciplinary Systems

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

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

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

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

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

Performance Benchmarks: Systematically collaborates successfully with other relevant partners

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

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

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

_____ Rotation Supervisor's Rating for Interdisciplinary Systems

_____ Transrotational Supervisor's Rating for Interdisciplinary Systems

_____ Competency Committee Member's Ratings for Interdisciplinary Systems

Advocacy

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

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

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

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

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

_____ Rotation Supervisor's Rating for Advocacy

_____ Transrotational Supervisor's Rating for Advocacy

_____ Competency Committee Member's Ratings for Advocacy

Program-Specific Competencies:

1. Teaching

Essential Component A: Knowledge of outcome assessment of teaching effectiveness

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

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

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

Assessment Methods: Review of intern's self-study; Case Presentation Rating Form—item 17; Peer Perception Survey—item 11;; Grand Rounds Presentation Rating Form—items 1-6.

_____ Rotation Supervisor's Rating for Teaching

_____ Transrotational Supervisor's Rating for Teaching

_____ Competency Committee Member's Ratings for Teaching

2. Officer Development

Essential Component A: Exhibits basic military knowledge and officership (i.e., criteria beyond professionalism as it pertains to being a uniformed services officer).

Performance Benchmarks: Demonstrates awareness of military protocols, such as uniform, grooming standards, and demeanor, across settings and with enlisted personnel, other officers, and civilian staff members; Shows familiarity with regulations impacting Navy officers and health providers such as the UCMG and DOD Instructions; Independently identifies and works to resolve ethical issues unique to military psychology.

Essential Component B: Demonstrates career commitment as a Navy Psychologist.

Performance Benchmarks: Seeks out opportunities to increase knowledge of unique aspects of Navy psychology; Is active in organizations relevant to Navy psychology (e.g., belongs to Division 19; volunteers for recruiting at national conferences; active in MSC community).

Assessment Methods: Direct supervisor observation and discussion during supervision; Review of intern's self-study; Review of intern's Fitness Report; Consultation Survey—Question 7; Interdisciplinary Team Member Survey—Question 6; Fitness Report.

_____ Rotation Supervisor's Rating for Officer Development

_____ Transrotational Supervisor's Rating for Officer Development

_____ Competency Committee Member's Ratings for Officer Development

Summary of Ratings:

Competencies	Supervisor Rating	Transrotational Supervisor Rating	3rd Rating	Average Rating
Research	_____	_____	_____	_____
Ethical/legal standards	_____	_____	_____	_____
Individual and cultural diversity	_____	_____	_____	_____
Professional values, attitudes, and behaviors	_____	_____	_____	_____
Communication/ interpersonal skills	_____	_____	_____	_____
Assessment	_____	_____	_____	_____
Intervention	_____	_____	_____	_____
Assessment	_____	_____	_____	_____
Supervision	_____	_____	_____	_____
Consultation/ Interpersonal/ Interdisciplinary Skills	_____	_____	_____	_____
Teaching*	_____	_____	_____	_____
Officer Development*	_____	_____	_____	_____

* Denotes program-specific competencies.

Average Rating of all Competencies: _____

For Rotations 1-3:

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

For Rotation 4:

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

Evaluation Comments: _____

_____

_____

_____

_____

_____ _____
Psychology Intern Rotation Supervisor(s)

_____ _____
Date Transrotational Therapy Supervisor

_____
Competency Committee Member

Intern Statement: I do/ do not concur with the above evaluation.

Intern Comments: _____
_____
_____
_____

APPENDIX B

Competency Assessment Rating Scale: Individual Supervisor

Naval Medical Center Portsmouth
Psychology Internship Training Program
Competency Assessment Rating Scale: Individual Supervisor's Form

Intern: _____ Supervisor_____

Supervisor's Role: _____Primary Rotation Supervisor ____Transrotational Supervisor

Rotation (circle one): Inpatient Outpatient I Outpatient II Elective: _____

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

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

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

Performance benchmarks listed on this form are for the 3.00 competency level, i.e., "Meets Criteria for Entry to Practice". Ratings below or above this level reflect comparison of these benchmarks with those of other developmental levels as listed in the training program's **Competency Benchmark** document. It is important to note that ratings are based on the judgment of the supervisor and members of the competency committee

relative to stated benchmarks as informed by various sources of data (i.e., our assessment toolkit). A more complete discussion of this rating scale, along with the program's justification for using it, is provided in the Internship Training Manual.

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

Averaged* Performance Targets Per Rotation Sequence

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

Performance Expectations:

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

* Averages are based on ratings made by each intern's rotation supervisor and transrotational supervisor, (and one other supervisor at specific times designated by the internship manual) all of whom compose the intern's competency committee.

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

Profession-Wide Competencies

1. Research:

Scientific Knowledge and Methods

_____**Essential Component A**: Independently applies scientific methods to practice

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

_____**Essential Component B**: Knowledge of core science

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

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

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

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 10 and 16; Peer Perception Survey—items 2, 3 & 9: Grand Rounds Presentation Rating Form—item 1.

_____Average of essential component ratings for Scientific Knowledge and Methods

Research/Evaluation

_____**Essential Component A**: Generation of knowledge

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

_____**Essential Component B**: Evaluation of outcomes

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

Assessment Methods: Discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 10 & 16; Peer Perception Survey—items 2, 3 & 9.

_____Average of essential component ratings for Research/Evaluation

____**Average rating for Research Competency** (Composed of Scientific Knowledge and Methods and Research/Evaluation)

2. Ethical Legal Standards and Policy

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—item 11; Peer Perception Survey—item 4.

_____Average of essential component ratings for Ethical Legal Standards and Policy

3. Individual and Cultural Diversity

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

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

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

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

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

> **Performance Benchmarks**: Independently articulates, understands, and monitors multiple cultural identities in interactions with others; Regularly uses knowledge of the role of culture in interactions to monitor and improve

effectiveness as a professional; Critically evaluates feedback and initiates consultation or supervision when uncertain about diversity issues with others

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; Case Presentation Rating Form—items 7 & 12; Work Samples Rating Form—items 10 & 22; Patient Perception Survey—item 4; Peer Perception Survey—item 5; Biopsychosocial and Ethics Consultation Survey—items 1-6; Peer Supervision Rating Scale—items 5 & 10.

_____Average of essential component ratings for Individual and Cultural Diversity

4. Professional values, attitudes, and behaviors

Professionalism

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

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

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

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

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of intern's self-study; End of Rotation Didactics Test; Support Staff Survey—item 2; Patient Perception Survey—items 1,2,3,&7; Interdisciplinary Team Member Survey—items 1,2,& 3; Consultation Services Survey—items 1 & 2; Grand Rounds Presentation Rating Form—Item 6.

_____Average of essential component ratings for Professionalism

Reflective Practice/Self-Assessment/Self-Care

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

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

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

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

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

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

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

_____Average of essential component ratings for Reflective Practice/Self-Assessment/Self-Care

____Average rating for Professional Values, Attitudes and Behaviors Competency (Composed of Professionalism and Reflective Practice/Self-Assessment/Self-Care)

5. Communication and interpersonal skills

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

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

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

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

____Essential Component C: Effective command of language and ideas

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

Assessment Methods: Supervisor's direct observation and discussion during supervision sessions; Review of intern's self-study; Work Samples Rating Form—items 21 & 24; Support Staff Survey—item 1; Patient Perception Survey—item 8; Peer Perception Survey—item 12; Interdisciplinary Team Member Survey—item 5; Consultation Services Survey—item 5; Peer Supervision Rating Form—items 1 & 8.

____Average of essential component ratings for Communication and interpersonal skills

Assessment

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

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

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

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

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

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

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

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; Case Presentation Rating Form—items 1-5; Work Samples Rating Form—items 1-8, 11-15, 17-19; Peer Perception Survey—item 1.

_____Average of essential component ratings for Assessment

7. Intervention

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

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

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

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

_____Essential Component C: Clinical skills and judgment

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

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

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

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

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

Assessment Methods: Direct supervisor observation and discussion during supervision sessions; Review of self-study; Case Presentation Rating Form—item 9; Work Samples Rating Form—items 9, 14,16, 23(a or b); Patient Perception Survey—item 9.

_____Average of essential component ratings for Intervention

8. Supervision

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

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

_____Essential Component B: Knowledge of procedures and practices of supervision

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

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

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

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

Performance Benchmarks: Demonstrates adaptation of own professional behavior in a culturally sensitive manner as appropriate to the needs of the supervision context and all parties in it; Articulates and uses appropriate repertoire of skills and techniques in supervisory process; Identifies impact of aspects of self in therapy and supervision

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

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

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

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

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

_____Average of essential component ratings for Supervision

9. Consultation and interprofessional/interdisciplinary skills:

Consultation

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

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

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

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

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

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

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

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

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

_____Average of essential component ratings for Consultation

Interdisciplinary Systems

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

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

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

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

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

Performance Benchmarks: Systematically collaborates successfully with other relevant partners

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

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

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

_____Average of essential component ratings for Interdisciplinary Systems

Advocacy

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

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

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

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

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

_____Average of essential component ratings for Advocacy

____**Average rating for Consultation and Interprofessional/Interdisciplinary Skills** (Composed of Consultation, Interdisciplinary Systems, and Advocacy)

Program-Specific Competencies:

1. Teaching

_____**Essential Component A**: Knowledge of outcome assessment of teaching effectiveness

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

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

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

Assessment Methods: Review of intern's self-study; Case Presentation Rating Form—item 17; Peer Perception Survey—item 11;; Grand Rounds Presentation Rating Form—items 1-6.

_____Average of essential component ratings for Teaching

2. Officer Development

_____Essential Component A: Exhibits basic military knowledge and officership (i.e., criteria beyond professionalism as it pertains to being a uniformed services officer).

> **Performance Benchmarks**: Demonstrates awareness of military protocols, such as uniform, grooming standards, and demeanor, across settings and with enlisted personnel, other officers, and civilian staff members; Shows familiarity with regulations impacting Navy officers and health providers such as the UCMG and DOD Instructions; Independently identifies and works to resolve ethical issues unique to military psychology.

_____Essential Component B: Demonstrates career commitment as a Navy Psychologist.

Performance Benchmarks: Seeks out opportunities to increase knowledge of unique aspects of Navy psychology; Is active in organizations relevant to Navy psychology (e.g., belongs to Division 19; volunteers for recruiting at national conferences; active in MSC community).

Assessment Methods: Direct supervisor observation and discussion during supervision; Review of intern's self-study; Review of intern's Fitness Report; Consultation Survey—Question 7; Interdisciplinary Team Member Survey—Question 6; Fitness Report.

_____Average of essential component ratings for Officer Development

APPENDIX C

Work Samples Rating Scale

Naval Medical Center Portsmouth Internship Training Program

Work Samples Rating Form

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

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

5 Outstanding
4 Good
3 Satisfactory
2 Needs Improvement
1 Deficient

Diagnostic Interview/Testing Reports

	Case I
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 needs better organization and a more logical flow of information. Some information required for differential diagnosis may be inferred but not specifically stated. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 HPI section attempts to describe patient's symptoms and functioning but may leave out some aspects of either or both. Rationale for diagnosis is not clearly spelled out and some information required for differential diagnosis is neither inferred nor provided. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

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

2.) Substance Use:

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

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

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

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

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

_____ N/A (Young child patient).

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

_____ 5 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated uncommonly well with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Patient's psychiatric, medical, and family psychiatric history is thoroughly and clearly documented. Information is integrated with current symptoms to clarify the diagnostic picture. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Patient's psychiatric, medical, and family psychiatric history is documented but not in great detail. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Patient's psychiatric, medical, and family psychiatric history is documented with some information omitted or presented in an unclear manner. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Patient's psychiatric, medical, and family psychiatric history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

4.) Psychosocial History:

_____ 5 Patient's psychosocial history is clearly and thoroughly documented. The information is integrated uncommonly well into the biopsychosocial formulation of the case. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Patient's psychosocial history is clearly and thoroughly documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Patient's psychosocial history is adequately documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Patient's psychosocial history is documented with some information omitted. Some information may need to be clarified. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Psychosocial history is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

5.) Mental Status Exam:

_____ 5 Intern's documentation reflects unusually thorough knowledge of mental status examination. The mental status section is clearly written and is fully congruent with the overall diagnostic impression. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Intern demonstrates good skills recording features of the mental status examination. Mental status section is clearly written. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Intern demonstrates adequate skills recording features of the mental status examination. Documentation is not specific enough in some areas. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Intern requires training to adequately document a mental status exam. Report may omit key components of the patient's mental status. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Mental Status is not documented or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

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

_____ 5 Report reflects thorough assessment of risk to harm self or others and is written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. A fully adequate crisis plan is documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Report reflects adequate assessment of risk to harm self or others and reflects good knowledge of research literature on risk and protective factors for suicide and homicide. A crisis plan is documented. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Report reflects meaningful assessment of risk to harm self or others and reflects basic knowledge of research literature on risk and protective factors for suicide and homicide. Crisis plans is documented but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Report reflects superficial assessment of risk to harm self or others. Risk and protective factors are not addressed and crisis plan may be absent. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Risk assessment is absent in the report or is done so in an extremely cursory manner. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

7.) Psychological Testing: (if applicable)

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

_____ 4 Report demonstrates good knowledge of test selection and provides accurate interpretation. Test findings are integrated with other clinical information to reach appropriate conclusions. Report reflects good working knowledge of psychometric theory ethical factors as they relate to the testing of this patient.

_____ 3 Report demonstrates adequate knowledge of test selection and provides a basic but accurate interpretation. Conclusions reflect some integration of test findings with other clinical information. Report reflects some knowledge of psychometric theory ethical factors as they relate to the testing of this patient.

_____ 2 Intern demonstrates a limited knowledge of test selection and provides a marginally accurate interpretation. Conclusions only superficially integrate test findings with other clinical information. There is little to no awareness of ethical issues pertinent to testing reflected in the report.

_____ 1 Report reflects a poor understanding of psychological testing. Intern does not appear to understand the basics of test selection and interpretation, and the report does not reflect an understanding of psychometric theory, nor does it address ethical considerations pertinent to the testing of this patient

_____ N/A

8.) Diagnosis:

_____ 5 Intern's report reflects an unusually strong knowledge of mental health classification and provides DSM-V diagnoses that are fully supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is clear in the report.

_____ 4 Intern's report reflects a strong knowledge of mental health classification and provides DSM-V diagnoses that are supported by the description of the presenting problem, history, and mental status findings. The basis for ruling out competing diagnoses is either explicit or strongly inferred from the way the report is written.

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

_____ 2 Report reflects a theoretical knowledge and understanding of basic diagnostic nomenclature but does not provide sufficient information to fully rule-in or rule-out specific diagnoses.

_____ 1 Report reflects significant deficits in understanding of the mental health classification system and/or ability to use DSM-V criteria to develop a diagnostic conceptualization.

9.) Recommendations and Disposition

_____ 5 Recommendations are formulated and consider patient's needs, military demands (if applicable), and available resources outside of the NMCP Mental Health Clinic, if applicable. The recommendations reflect solid knowledge of evidence-based practice and specifies the nature of services needed in order to address the patient's issues (e.g., return to the clinic for psychotherapy, referral for medication management, recommendation for specialized treatment). For active-duty service members, fitness/suitability for duty is clearly documented and explained.

_____ 4 Recommendations are formulated and take into account patient's needs, military demands, and available resources outside of the NMCP Mental Health Clinic, if applicable. A general description of the types of services needed to address the patient's concerns is offered and is reasonably complete, though not highly specific. Fitness/suitability for duty is clearly documented for active duty members but may not be fully explained.

_____ 3 Intern formulates recommendations that include appropriate general plans for treatment or referral, but recommendations may lack specificity or may fail to take into account available community/military resources. Fitness/suitability for duty is documented but not explained.

_____ 2 Intern is unable to specify more than a very general and nonspecific post-interview plan for the patient. It may not be clear whether or not the patient is returning to the clinic for additional services, if referrals have been made for treatment elsewhere, and/or if follow-up treatment is needed. Statement regarding fitness/suitability for duty may be absent or inaccurate.

_____ 1 Intern does not provide recommendations for post-interview follow-up care or provides recommendations that are clearly inappropriate.

10.) Sensitivity to Biopsychosocial Variables**:**

_____ 5 Report reflects strong awareness of cultural issues relevant to the patient, including how these issues may influence the patient's psychosocial history, current symptoms, and focus of treatment (if applicable). When appropriate, attention is given to how cultural differences between the intern and the patient could have affected the patient's clinical presentation in the interview.

_____ 4 Report reflects awareness of cultural issues relevant to the patient, including how these issues may influence reported the patient's psychosocial history, current symptoms, and focus of treatment (if applicable).

_____ 3 Intern demonstrates basic knowledge of cultural issues relevant to the patient and tries 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 variables in need of attention in this report are noted by rater.

11.) Overall Written Communication Skills

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

_____ 4 Report is clear and summarizes major relevant issues. Recommendations are useful and related to the referral question.

_____ 3 Report covers essential points without serious error but needs polish in cohesiveness and organization. Recommendations are useful and relevant but may not fully address the referral question. Grammatical/spelling errors are minimal, if present.

_____ 2 Report covers most essential points but fails to summarize patient information into a cohesive report. Report reflects difficulty in formulating recommendations to appropriately answer referral questions. The report may have minor grammatical/spelling errors.

_____ 1 Report has incomplete information, lack of structure or confusing organization, poor grammar or spelling, or inconsistent information. Report may contain material that does not apply to current patient.

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

12.) Subjective:

_____ 5 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and reflects judicious selection of information that addresses important clinical issues without unduly divulging personally sensitive information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is concise and free of extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Documentation addresses current issues/status within the context of initial presentation and prior sessions. Note is either not concise or contains some extraneous information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Documentation addresses current issues/status independently of the context of initial presentation and prior sessions. Note is either inappropriately brief or contains clearly extraneous information. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Note does not provide information regarding patient's current concerns or does so in a manner that shows no continuity with previous sessions and/or is not clearly written. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

13.) Objective: Observed Features

_____ 5 Intern documents objective status of the patient in a manner that reflects an uncommonly thorough understanding of the observable features of the mental status examination and in a manner that reflects session to session variability in the patient's presentation. Documentation does not give the impression that a formal mental status examination was conducted unless that was indeed the case. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Intern documents objective status of the patient in a manner that reflects a solid understanding of the observable features of the mental status examination and in a manner that reflects some session-to-session variability in the patient's presentation. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Notes reflect the recording of objective features of the patient's status at each session in a manner that reflects a basic understanding of the observable features of a mental status examination. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Intern's notes contain fragments of a mental status-like examination in reporting objective features of the patient's status in each session. There may be little session to session variability and there is the appearance of inappropriate cutting and pasting from past notes. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 One or more notes does not reflect objective features of the patient's status at time of therapy session. If an audio/video recording of the encounter was submitted, there is evidence of marked incongruence between the written report and the recording.

14.) Objective: Measurements

_____ 5 Progress notes include data from one or more objective tests/instruments designed to evaluate session by session patient status/outcomes. Outcome measures are appropriate for the presenting problem. Notes provide accurate and appropriate interpretation of these data relative to treatment goals and prior test scores.

_____ 4 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome. Notes provide a basic interpretation of these data relative to treatment goals and prior test scores.

_____ 3 Progress notes include data from at least one objective test/instrument designed to evaluate session by session patient status/outcome, but the instrument may not be well matched to the problem being treated . Notes may not provide an interpretation of the finding relative to treatment goals and/or prior test scores.

_____ 2 At least one note contains data from an objective test/instrument designed to evaluate session by session patient status/outcome but does not contain an interpretation of the findings or provides an incorrect interpretation of the finding.

_____ 1 None of the progress notes contains data from an objective test/instrument.

15.) Assessment of Suicide and Homicide Risks:

_____ 5 Notes reflect an unusually thorough session by session assessment of risk to harm self or others and are written in a manner that demonstrates strong knowledge of research literature on risk and protective factors for suicide and homicide. Note refers to prior findings as needed and does not imply that a comprehensive risk assessment was performed within the course of the therapy appointment unless the particulars of the case demonstrate that such was needed. When indicated by case demands, a fully adequate crisis plan is documented in each progress note in a manner that does not suggest simple cutting and pasting of information. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is exceptionally high.

_____ 4 Notes reflect a thorough session by session assessment of risk to harm self or others and reflect good knowledge of research literature on risk and protective factors for suicide and homicide. Note does not document information that was not actually collected during the session but may refer to findings previously established. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is high.

_____ 3 Notes reflect meaningful assessment of risk to harm self or others and reflect basic knowledge of research literature on risk and protective factors for suicide and homicide. A basic crisis plan is documented, if

indicated by the particulars of the case, but may need to be refined or expanded. If an audio/video recording of the encounter was submitted, congruence between the written report and the recording is adequate.

_____ 2 Notes reflects superficial or inconsistent assessment of risk to harm self or others. Risk and protective factors are inadequately or inconsistently addressed. If a crisis plan is indicated, it may be missing or inadequate. If an audio/video recording of the encounter was submitted, there is evidence of mild incongruence between the written report and the recording.

_____ 1 Risk assessment is absent or highly inadequate/inconsistent in one or more of the progress notes. If an audio/video recording of the encounter was submitted, there may be evidence of marked incongruence between the written report and the recording.

16.) Treatment Plan

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

_____ 4 Progress notes include a treatment plan that is consistent with patient's needs, military demands, biopsychosocial variables, and ethical practice guidelines. The plan reflects awareness of evidence-based practice and specifies goals of treatment, and treatment modality. Outcome measures are incorporated directly into the treatment plan and treatment goal setting. Indications for changes in the treatment plan are reported, as is the basis for such. Documentation reflects awareness of the efforts of other members of the treatment team.

_____ 3 Progress notes include a basic treatment plan that is appropriate for the patient but one that is not highly reflective of unique patient needs or military demands. There is no indication that biopsychosocial variables and/or ethical issues impacted formation of treatment plan. Treatment goals are not expressed in measurable terms and/or not directly linked to an outcome measure.

_____ 2 Progress notes include a basic treatment plan that is appropriate for the patient but is lacking in detail and is not reflective of unique patient needs or military demands. Opportunities to incorporate biopsychosocial variables and/or ethical considerations appear to have been missed. Treatment goals are not operationalized, treatment modalities are not adequately described, and/or current status of the patient relative to the presenting problem(s) is not described in objective terms.

_____ 1 Notes provide no treatment plan or one that appears to be either a template (i.e., the same plan used for every patient) or inappropriate.

Evaluation of Recorded Diagnostic Interview

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

17.) Assessing Presenting Problem:

_____ 5 Assesses the referral question in an uncommonly thorough manner. Inquiries 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. For active-duty patients, assesses how symptoms impact performance of military duties and the ways in which military demands contribute to symptom presentation.

_____ 4 Assesses the referral question thoroughly. Inquiries 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. For active-duty patients, assesses how symptoms impact performance of military duties and the ways in which military demands contribute to symptom presentation.

_____ 3 Assesses the referral question adequately. Inquiries about patient's symptoms, including precipitants, onset, frequency, and duration of symptoms and assesses the impact of these symptoms on patient's social and occupational functioning.

_____ 2 Assesses the referral question by inquiring about patient's symptoms, however, the assessment is incomplete. May leave out precipitant, onset, duration and/or frequency of symptoms, or fails to assess the impact of these symptoms.

_____ 1 Unable to generate appropriate questions to address the referral question. Symptoms are collected in a random fashion as reported by the patient.

18) History Taking:

_____ 5 Assesses patient's psychiatric history, medical history, family psychiatric history, military history (if indicated) developmental/educational history, psychosocial history and substance use history in an unusually thorough manner. Interview style is indicative of intern's ability to form questions that relate historic data to current symptoms and possible diagnoses. Asks appropriate follow up questions that fully clarify the historical picture with special reference to Axis II features and developmental disorders.

_____ 4 Assesses patient's psychiatric history, medical history, family psychiatric history, military history (if indicated), developmental/educational history, psychosocial history and substance use history thoroughly. Asks appropriate follow up questions that are adequate for assessing presence or absence of maladaptive personality features and developmental disorders.

_____ 3 Collects adequate historic and relevant information. May fail to ask important follow up questions at times during the interview and does not obtain adequate information relevant to maladaptive personality traits and/or developmental disorders.

_____ 2 Struggles to gather relevant historical data and frequently fails to ask important follow up questions and/or leaves out important information in the interview.

_____ 1 Clearly fails to gather significant parts of the patient's psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and/or substance use history.

19.) Assessment of Suicide and Homicide Risks:

_____ 5 Intern assesses suicide and homicide risks fully and in an uncommonly thorough manner. Interview style reflects strong knowledge of research literature on risk and protective factors for suicide and homicide. If indicated, intern discusses a well thought-out crisis plan with the patient in a clear and appropriate manner.

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

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

_____ 2 Intern assesses suicide and homicide risks superficially. May fail to ask appropriate probing questions about risk factors, fail to assess protective factors, and/or fail to discuss with the patient, if indicated, a crisis plan.

_____ 1 Intern fails to recognize safety issues and does not ask questions about suicidal/homicidal ideations, intent or plan.

20.) Interview Skills:

_____ 5 Interview is unusually well organized and flows naturally. Intern conveys warmth, genuineness and empathy during the interview. Intern recognizes patient's emotions in the interview, is sensitive to patient's emotional states and cultural background, and is able to ask questions regarding sensitive material. Intern is able to build therapeutic alliance with the patient in the interview.

_____ 4 Interview is well organized. Intern recognizes patient's emotions in the interview, is sensitive to patient's cultural background, and is able to ask questions regarding sensitive material. Intern is able to build a therapeutic alliance with the patient in the interview.

_____ 3 Intern demonstrates adequate information gathering skills and is aware of patient's cultural background. Interview is organized and intern is flexible in the interview to accommodate patient's emotional needs or cultural background.

_____ 2 Intern is able to gather information through pre-selected structured questions. Intern is not flexible in the interview to accommodate patient's emotional needs or cultural background. Intern is unable to convey warmth or empathy and/or is unable to build therapeutic alliance with the patient.

_____ 1 Intern asks questions in a seemingly random fashion, is insensitive to patient's emotions and cultural background, and/or does not foster a good working alliance with the patient.

Evaluation of Recorded Therapy Session

21.) Therapeutic Relationship:

_____ 5 Intern demonstrates a strong therapeutic alliance with patient. Intern appears comfortable and relaxed in session and handles anxiety-provoking or awkward situations effectively so that they do not undermine therapeutic success.

_____ 4 Intern demonstrates a positive therapeutic alliance with patient. Intern is generally comfortable and relaxed in session but may occasionally appear anxious in awkward situations. Intern can process these situations with patient.

_____ 3 Intern demonstrates an adequate relationship with patient. Intern may occasionally appear anxious in awkward situations.

_____ 2 Intern demonstrates marginal rapport with patient and/or appears anxious or awkward during much of the session.

_____ 1 Intern alienates patient and/or shows little ability to recognize problems in the therapeutic relationship.

22.) Sensitivity to Biopsychosocial Variables:

_____ 5 Intern takes the initiative to discuss individual differences in terms of biopsychosocial variables comfortably and sensitively with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session. If the patient is from a distinct minority group, it is apparent that the intern understands how that culture may influence mental health issues.

_____ 4 Intern takes the initiative to discuss individual differences in terms of biopsychosocial variables with patient when appropriate. Recognizes when more information is needed regarding the impact of patient's cultural background on current or past experiences and seeks such information during the session.

_____ 3 Interns shows adequate ability to discuss biopsychosocial variable differences that exist between self and patient. Intern does not initiate discussion with patient about these differences unless brought up by patient. Intern is open to patient discussing experiences related to cultural background but usually does not specifically ask about these experiences.

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

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

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

23a.) Intervention (Cognitive Processing Therapy or Prolonged Exposure Therapy):

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

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

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

_____ 2 Intern has difficulty staying on track with the protocol. Intern may have difficulty allotting time to session components and fails to finish the session. Or intern may follow the timeline rigidly even when the patient clearly does not understand or accept the intervention.

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

23b.) Intervention (CBT, ACT, DBT, Child Therapy, Crisis Management):

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

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

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

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

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

24.) Interpersonal Process

_____ 5 Intern's style reflects a strong ability to use personal responses to the patient to formulate hypotheses about the patient during the session. Intern responds appropriately to metaphoric and nonverbal content, and recognizes and highlights underlying affect, cognition or themes from content. Intern appears to be

aware of own issues that impact therapeutic process and discusses/processes transference/countertransference issues effectively in the session when indicated.

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

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

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

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

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

Comments: _____

_____

_____

Appendix D
Psychiatry Inpatient Process Group Evaluation Tool

Psychiatry Inpatient Process Group Evaluation Tool

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

APPENDIX E

REQUIRED READINGS

General Reading List per Competency Domains

Competency Domains	First Rotation	Second Rotation	Third Rotation	Fourth Rotation
Scientific Knowledge and Methods				
Research/Evaluation				
Ethical Legal Standards and Policy				
Individual and Cultural diversity				
Professionalism				
Reflective practice/Self-Assessment/Self-Care				
Communication and interpersonal skills				
Assessment				

Intervention				
Supervision				
Interdisciplinary Systems				
Consultation				
Teaching				
Advocacy				

APPENDIX F

Case Presentation Rating Scale

Naval Medical Center Portsmouth Internship Training Program

Case Presentation Rating Form

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

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

5 Outstanding
4 Good
3 Satisfactory
2 Needs Improvement
1 Deficient

1.) Case Material:

_____ 5 Intern presented the patient's current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history in an unusually thorough and well-organized fashion. Intern was able to skillfully integrate historic information with current symptoms to clarify the clinical picture.

_____ 4 Intern presented the patient's current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history thoroughly and in an organized fashion. There was evidence of integration of historic information with current symptoms.

_____ 3 Intern presented most relevant patient information, such as current symptoms, history of present illness, psychiatric history, medical history, family psychiatric history, developmental/educational history, psychosocial history and substance use history, but either neglected to collect some potentially valuable clinical data or provided less than fully clear symptom/data descriptions. There was only basic evidence of ability to integrate historic information with current symptoms.

_____ 2 Intern presented most relevant patient information but left out some key clinical/historical facts or provided vague descriptions of such. There was little evidence of intern's ability to integrate historic information with current symptoms.

_____ 1 Intern presented patient information in a disjointed fashion and/or either provided vague descriptions of clinical/historical facts or failed to present major symptom clusters or clinical/historical facts.

2.) Assessment of Suicide and Homicide Risks:

_____ 5 Intern presented an unusually thorough suicide and homicide risk assessment. Presentation reflected strong knowledge of research literature on risk and protective

factors for suicide and homicide. Intern formulated an exceptional crisis plan, if indicated, and appropriate protective actions were taken if necessary.

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

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

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

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

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

_____ 5 Intern skillfully selected tests to address features of the case and offered a highly sophisticated interpretation of the findings consistent with actual test data provided in summary format (e.g., test scores or scales) as part of the presentation. Presentation reflected strong knowledge of psychometric theory, and the roles played by biopsychosocial variables and professional ethics in the use of psychological tests.

_____ 4 Intern demonstrated adequate knowledge of test selection and provided an accurate interpretation of test findings consistent with actual test data provided in summary format (e.g., test scores or scales) as part of the presentation. Presentation reflected knowledge of psychometric theory and/or awareness of the roles played by biopsychosocial variables and professional ethics in the use of psychological tests.

_____ 3 Intern demonstrated appropriate use of one or more standard psychological tests without specifying why a particular test was used. Interpretation of findings was accurate, as evident from test data presented with the case, but quite basic. Presentation reflected only rudimentary knowledge of psychometric theory and/or awareness of the roles played by biopsychosocial variables and professional ethics in the use of psychological tests.

_____ 2 Intern referenced test findings without providing summary test scores/scales or provided summary test data but offered only a very basic interpretation. Presentation did not reflect knowledge of psychometric theory or awareness of the roles played by biopsychosocial variables and professional ethics in the use of psychological tests.

_____ 1 Case presentation included psychological test data but interpretation was inaccurate. Presentation reflected deviation from standard practice, may have included interpretation errors due to lack of awareness of biopsychosocial variables, and/or may have included ethically questionable practices.

_____ N/A

4.) Diagnosis:

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

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

_____ 3 Intern demonstrated basic knowledge of diagnostic nomenclature and the DSM-V, and his/her diagnostic formulation appeared adequate, though symptom descriptions were not sufficiently detailed to provide overwhelming support for the diagnoses and/or facts needed to rule out other diagnoses were not presented in a thorough manner.

_____ 2 Intern demonstrated only a rudimentary theoretical knowledge and understanding of basic diagnostic nomenclature and the DSM-V. Interns omitted a number of patient facts needed to support his/her diagnostic formulation and/or to rule out different diagnoses.

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

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

_____ 5 Intern produced an unusually strong case conceptualization within own preferred theoretical orientation and was able to draw multiple insights from other orientations. Case formulation demonstrated strong knowledge of current literature regarding preferred orientation and evidence-based treatments.

_____ 4 Intern produced a good case conceptualization within own preferred theoretical orientation and was able to draw some insights from other orientations. Case formulation demonstrated knowledge of current literature regarding preferred orientation and evidence-based treatments.

_____ 3 Intern produced an adequate case conceptualization within own preferred theoretical orientation. Case formulation demonstrated basic knowledge of current literature regarding preferred orientation and evidence-based treatments.

_____ 2 Intern's case conceptualization reflected some limitations in theoretical understanding of the intern's chosen orientation and demonstrated a limited appreciation of the current literature regarding preferred orientation and evidence based treatments.

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

_____ N/A

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

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

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

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

_____ 2 Intern provided a description of psychotherapy interventions that reflects only a very rudimentary understanding of psychological treatment. Outcome data are either not presented or are presented in a manner that does not that support intern's description of therapeutic progress.

_____ 1 Intern provides a description of psychotherapy interventions that are inappropriate for the given case, reflect poor understanding of psychological treatment issues, or do not take into consideration outcome data.

_____ N/A

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

_____ 5 Intern demonstrated an unusually thorough understanding of how demands of military service and military life impact patient's functioning and treatment options. Intern identified operational needs, and military issues present in the case, and, if indicated, illustrated how he/she addressed them proactively with the patient and/or the command.

_____ 4 Intern demonstrated good understanding of how demands of military service and military life impact patient's functioning and treatment options. Intern identified some operational needs, and military issues present in the case, and illustrated how he/she addressed them at some point in the treatment process with the patient and/or the command

_____ 3 Intern demonstrated some understanding of military issues and operational demands present in the case but may have failed to take them into full consideration when making recommendations regarding the case.

_____ 2 Intern demonstrated limited awareness of important military issues and demands present in the case

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

_____ N/A

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

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

_____ 4 Intern identified need for consultation and initiated requests for such in a manner reflective of solid awareness of the value of interdisciplinary approaches to treatment.

_____ 3 Intern identified need for consultation and initiated requests for such in a manner reflective of some understanding of and appreciation for the value of interdisciplinary approaches to treatment.

_____ 2 Intern appeared to have a limited awareness of the need for consultation to other professional services and appeared to have limited insight regarding the value of interdisciplinary approaches to treatment.

_____ 1 Intern appeared to have no awareness of the need for consultation to other professional services and appeared to have no understanding of the value of interdisciplinary approaches to treatment.

_____ N/A

9.) Recommendations:

_____ 5 Recommendations for a treatment case took into account multiple patient needs and military demands, and took into consideration biopsychosocial variables. 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.

For a testing/assessment case, recommendations provided to referral sources and the patient fully addressed the referral question and took into account multiple patient's needs and military demands and took into consideration biopsychosocial variables. An unusually thorough discussion of the implications of assessment findings for prognosis and clinical management of the case was presented.

_____ 4 Recommendations for a treatment case took into account various patient needs and military demands, and took into consideration at least one biopsychosocial variable.. Intervention strategies recommended were evidence based and a thorough treatment plan was outlined in which treatment goals were specified, patient strengths and limitations were delineated, a treatment modality was identified, and estimated length of treatment was provided.

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

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

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

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

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

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

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

10.) Scholarly Review of the Literature:

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

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

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

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

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

11.) Ethical and Legal Issues:

_____ 5 Intern demonstrated unusually strong knowledge of the ethical principles and military laws and regulations pertinent to the case. Intern demonstrated unusually strong judgment regarding actions to take to resolve or address ethical issues, if such were identified. Information reflected a very solid understanding of an ethical decision-making model.

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

_____ 3 Intern demonstrated some understanding of the ethical principles, and military laws and regulations pertinent to the case. If such were identified, intern offered only a vague prescription for resolving ethical issues or indicated only the need to consult with a supervisor. Either there was only vague reference to an ethical decision-making model or use of one was not well executed.

_____ 2 Intern demonstrated only superficial awareness of potentially important ethical and legal issues present in the case, and did not discuss viable approaches to resolving ethical concerns, if any were identified. There was no indication that an ethical decision-making model was being used to structure the discussion.

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

12.) Diversity Issues:

_____ 5 Intern demonstrated strong acknowledgement and respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Recognized when more information was needed regarding patient differences and had clearly independently located and incorporated this information into assessment and/or therapy. The intern interwove diversity issues skillfully throughout the presentation. The intern genuinely reflected on his/her own diversity characteristics and how these characteristics influenced the therapy relationship and his/her responses to the patient.

_____ 4 Intern recognized individual differences with the patient and demonstrated respect for differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Case presentation demonstrated awareness of own limits in expertise and efforts to take diversity issues into consideration in case conceptualization/assessment and treatment planning. The intern showed an ability to reflect on his/her own diversity characteristics and an openness to grappling with how

these characteristics influenced the therapy relationship and his/her responses to the patient.

_____ 3 Intern recognized individual differences with the patient and was respectful of differences between self and the patient in terms of race, ethnicity, culture and other individual/cultural variables. Intern made some efforts to take diversity issues into consideration in case conceptualization/assessment and/or treatment planning. The presentation reflected an unsophisticated use of the ADDRESSING framework.

_____ 2 Intern demonstrated some recognition of individual differences between self and the patient but was unable to take diversity issues into full consideration when reaching case conceptualization/assessment and/or during treatment planning. The presentation of the ADDRESSING model appeared superficial and without an attempt at genuine reflection.

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

13.) Consultation Issues:

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

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

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

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

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

14.) Advocacy Issues:

_____ 5 Intern intervened with others on behalf of the patient to promote changes positively impacting the patient's functioning and/or wellbeing. Intern's actions fostered self-advocacy on the part of the patient and reflected intern's awareness of the need to

develop alliances with relevant individuals/groups and/or to engage groups with differing viewpoints around the issue to promote change.

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

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

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

_____ 1 Intern did not address advocacy issues.

15.) Use of Outcome Measures

_____ 5 Intern provides data indicative of a consistent use of outcome measures in support of psychotherapy efforts. Intern describes factors playing a role in selection of specific measures and summarizes what he/she has learned about individual patients and about the provision of psychotherapy services because of collection of such data. Examples of the integration of outcome measures into base line problem definitions, treatment goal establishment, and documentation of status/response to treatment are provided via submission of specific progress notes.

_____ 4 Intern provides data indicative of use of outcome measures in support of psychotherapy efforts for some of their patients. Intern describes factors playing a role in selection of specific measures or summarizes what he/she has learned about individual patients and about the provision of psychotherapy services because of collection of such data. There is evidence that problems, treatment goals, and appraisals of status are linked to specific outcome measures as demonstrated by presentation of specific progress notes.

_____ 3 Intern provides data indicative of his/her ability to use outcome measures and/or a basic explanation of their appreciation for the role that such measures play in the provision of psychotherapy. Progress notes are included that illustrate the role of outcome measures in treating patients.

_____ 2 Intern provides minimal data indicative of his/her ability to use outcome measures and/or a rudimentary explanation of their appreciation for the role that such measures play in the provision of psychotherapy.

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

16.) Teaching Ability:

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

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

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

_____ 2 Intern's presentation suggested limited ability to function in a teaching role, i.e., intern communicated with difficulty, struggled to articulate concepts to be presented, and was only marginally effective in answering questions.

_____ 1 Information presented during the presentation was difficult to follow and major points were poorly articulated. Responses to questions were not handled in a manner that promoted learning.

17.) Peer Consultation:

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

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

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

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

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

Comments: _____

_____

_____

_____

_____

_____

APPENDIX G

Peer Perception Survey

Naval Medical Center Portsmouth Internship Training Program

Peer Perception Survey Completed following the Case Presentation

Date: _____ Presenting Intern: _____ Rating Intern: _____

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

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

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

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

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

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

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

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

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

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

____ 8.) The intern demonstrated the ability to reflect on his or her responses to the patient presented, including with regard to biopsychosocial variables.

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

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

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

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

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

APPENDIX H
Intern Grand Rounds Presentation Rating Form

Intern 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. Intern demonstrated expertise and competence in the subject.	1 2 3 4 5
2. Intern presented material in clear and orderly fashion.	1 2 3 4 5
3. Intern presented material at a level and in a manner that facilitated audience learning.	1 2 3 4 5
4. Intern paced material well.	1 2 3 4 5
5. Intern responded adequately to questions and other needs of the audience.	1 2 3 4 5
6. Intern's presentation style was engaging and professional (eye contact with audience, audible speech, conversational style rather than reading directly from slides).	1 2 3 4 5

APPENDIX I

Patient Perception Survey

Naval Medical Center Portsmouth Internship Training Program

Patient Perception Survey

Date: _____ Administrative Assistant: _____ Intern:_____

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

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

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

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

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

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

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

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

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

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

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

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

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

_____ 8.) You feel comfortable working with _____.

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

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

APPENDIX J

Consultation Services Survey

Naval Medical Center Portsmouth Internship Training Program

Consultation Services Survey

Date: _____ Administrative Assistant: _____ Intern: _____

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

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

Rotation (circle one): Inpatient Outpatient I Outpatient II Health/Neuropsychology/Child

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

Initials of referral source: _____

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

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

Command Directed Referral Another Mental Health Provider Other: _____

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

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

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

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

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

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

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

_____ 6.) The intern 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:

_____

APPENDIX K

Interdisciplinary Team Member Survey

Naval Medical Center Portsmouth Internship Training Program

Interdisciplinary Team Member Survey

Date: _____ Administrative Assistant: _____ Intern: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Health/Neuropsychology/Child

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

Initials of Team Member:_____ Profession: _____

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

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

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

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

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

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

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

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

_____ 7.) The intern showed proper military bearing as a member of this team.

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

_____
_____
_____

APPENDIX L

Support Staff Survey

Naval Medical Center Portsmouth Internship Training Program

Support Staff Survey:

Date: _____ Administrative Assistant: _____ Intern: _____

Rotation (circle): Inpatient Outpatient I Outpatient II Health/Neuropsychology/Child

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

Initials of support staff: _____

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

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

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

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

_____ 2.) _____ behaves in a professional manner.

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

_____ 4.) _____ utilizes your services appropriately.

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

_____
_____
_____
_____

APPENDIX M

Biopsychosocial and Ethics Consultation Survey

Naval Medical Center Portsmouth Internship Training Program 2022-2023

Biopsychosocial and Ethics Consultation Rating Form

Date of Consultation: _____ Intern/Trainee: _____

Supervisor (s): _____
Biopsychosocial and EthicsLiaison: _____

Rotation (circle one): Inpatient Outpatient I Outpatient II Elective: _____

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

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

The trainee will demonstrate awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal backgrounds and characteristics as broadly defined and consistent with APA policy.

_____1. The intern demonstrated awareness of ***self*** as shaped by biopsychosocial and ethical factors.

*The intern was able to independently articulate, monitor and apply knowledge of **self** as a cultural being in assessment, treatment and/or consultation. The intern completed their own cultural assessment* prior to the 1st consultation and was able to discuss how one's own cultural heritage and recognized areas of privilege have influenced one's self and practice, in both the initial and subsequent consultations.*

_____2. The intern independently monitors and applies knowledge of ***others*** as shaped by individual and cultural factors in assessment, treatment and consultation

*The intern independently articulates, monitors and applies knowledge of **others** as cultural beings in assessment, treatment and consultation. The intern was able to identify and discuss the intersectionality of various multicultural factors impacting the patient, as well as the potential impact of these factors on the patient and on informing therapy and determining therapeutic outcomes.*

_____ 3. The intern independently acknowledges, monitors and applies knowledge of ***self and others*** as shaped by individual and cultural factors within the context of both in vivo and therapeutic experiences.

*The intern was able to independently articulate, understand and monitor multiple cultural identities in interactions between **self and with others**. Intern was able to identify factors within self i.e. implicit biases, which might have an impact on others. The intern was cognizant of cultural factors impacting transference and countertransference within the context of the therapeutic relationship. The intern seeks to improve their effectiveness as a professional by critically evaluating feedback and initiating supervision or consultation when uncertain about* biopsychosocial *issues with others.*

_____ 4. The intern is cognizant of and appropriately ***applies knowledge***, skills and attitudes regarding intersecting and complex dimensions of biopsychosocial and ethical factors, based on individual and cultural context.

*The intern was able to openly discuss and independently articulate an integrative conceptualization of biopsychosocial and ethical factors as they impact **patient(s), self and/or others**. Intern adapts one's professional behavior in a culturally sensitive manner, as appropriate to meeting the needs of the patient. The intern is mindful of avoiding harm and articulates/uses alternative, culturally appropriate skills (competently adapting one's therapeutic repertoire) or techniques in treating the patient. The intern educates one's self on diverse sources of information, including research or literature, to integrate cultural considerations into treatment planning and culturally inform relevant best practice(s).*

* Prior to the 1st Biopsychosocial and Ethics Consultation, the intern will complete their own cultural self-assessment as outlined in "*Becoming a Culturally Responsive Therapist: Doing Your Own Cultural Assessment*" from Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy. Jan 2016. 3rd Ed. P.A. Hays.

APPENDIX N

Peer Supervision Rating Form

Naval Medical Center Portsmouth Internship Training Program

Peer Supervision Rating Form

Date: _____ Peer Supervisor: _____ Rater: _____

Please indicate whether you are:

Peer Supervisee: ____ Transrotational Supervisor: _____

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

_____ 1.) Peer Supervisor provided a sense of acceptance and support.

_____ 2.) Peer Supervisor established clear boundaries.

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

_____4). Peer Supervisor helped the supervisee conceptualize the case.

_____5.) Peer Supervisor raised biopsychosocial and ethicsissues relevant to the case.

_____ 6.) Peer Supervisor offered practical and useful case-centered suggestions.

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

_____ 8). Peer Supervisor conveyed active interest in helping supervisee grow professionally.

_____ 9). Peer Supervisor maintained appropriate and useful level of focus in supervision.

_____10.) Peer Supervisor was respectful of differences in biopsychosocial variables 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 O

Outpatient Supervision Contract

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

Outpatient Rotation I & II

Rotation Start Date: _____
Rotation Completion Date: On or about _____

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

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

disorders, trauma-related issues, psychotic disorders, and relational and occupational problems). This rotation facilitates the development of psychological assessment skills and psychotherapy based on psychological theory and research, and emphasizes evidence based treatment modalities. The intern will have opportunities to demonstrate skills and experience in diagnostic interviewing, psychological testing, treatment planning, short-term psychotherapy and interdisciplinary team participation. In addition, the intern will be exposed to military-specific activities such as security screenings and fitness-for-duty evaluations.

There will be rotation-specific reading assignments, which will be individualized based on training needs and the intern's specific interests. The Biopsychosocial and EthicsLiaison will remain available to consult with intern and supervisor throughout the rotation.

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

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

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

  - The expectation that the intern will voice disagreements and differences of opinion.
  - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate, or obtain assistance for, the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner, or the intern poses a threat to self or others.

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

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

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

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

Performance Evaluation:

At the end of the Outpatient I and II rotations competency ratings are made, independently, by the NMCP outpatient supervisor, and the intern's Transrotational supervisor as described in the Training Manual. Levels of competency development expected at the end of these rotations are outlined in the Competency Assessment Rating Scale, which is contained in the program's Training Manual. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se, nor are rotations repeated when performance is subpar. An intern obtaining ratings at or above "Acceptable" is considered to be in good standing in the training program. An intern

whose competency ratings fall below the minimally acceptable level, as defined in the training manual, will be placed in a remedial status and provided with a remedial plan. Remedial plans target specific performance deficiencies and outline measures designed to assist the intern in over-coming performance/competency obstacles. If the remedial plan does not bring an intern up to expected competency levels by the next rating period, the intern may be given a second period of remediation or, conversely, at the recommendation of the Training Committee may be referred to the Graduate Medical Education Committee, which could result in the intern's placement on Command Probation. The intern's rights to due process are strictly maintained throughout this process.

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

NMCP Rotation Supervisor

_____ Date: _____

Branch Clinic or Operational Supervisor

APPENDIX P

Inpatient and Emergency Services Supervision Contract

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

Inpatient and Emergency Services Rotation

Rotation Start Date: _____
Rotation Completion Date: On or about _____

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

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

The inpatient rotation will be conducted primary on the psychiatric units located in Building 2 of NMCP. These units provides intensive inpatient psychiatric treatment for acute or severe psychiatric illnesses and for dually diagnosed patients (i.e., patients diagnosed with a substance use disorder plus a psychiatric disorder). These units serve active duty patients and a lesser

number of adult family members. The intern will function as a treatment team member who is assigned a small caseload for whom he/she is responsible for coordinating team treatment planning, consulting with family members and military commands, and providing individualized therapy and assessment services. The intern will also be responsible for providing group therapy four times per week to the psychiatric units. In addition, the intern will be on call with psychiatric residents for emergency room psychiatric consultations at a frequency to be determined at the start of the rotation.

There will be rotation-specific reading assignments, which are individualized based on training needs and the intern's specific interests. The Biopsychosocial and EthicsLiaison will remain available to consult with intern and supervisor throughout the rotation.

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

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

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

- The expectation that the intern will voice disagreements and differences of opinion.
- Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.

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

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

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

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

Performance Evaluation:

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

plans will be made at that time to remediate any deficiencies. If a remedial plan does not bring an intern up to required competency levels by the next rating period, the intern may be placed on Command Probation in the event the Training Committee elects to refer the intern to the Graduate Medical Education Committee for deficient performance.

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

Rotation Supervisor

APPENDIX R

Substance Abuse Rotation Contract

SUPERVISION CONTRACT:
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
PSYCHOLOGY DEPARTMENT
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Substance Use Disorders Rotation

Rotation Start Date: _____
Rotation Completion Date: On or about _____

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

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale. This rotation allows the intern to develop and express clinical competencies within the context of an outpatient substance abuse rehabilitation program. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. The intern will attend and participate in morning team meetings, interview new patients, develop/monitor treatment/discharge plans, provide individual therapy/crisis intervention, participate in group therapy, and conduct psychological testing as needed. The intern will consult with other professionals on the interdisciplinary team and other medical specialists within this facility to provide integrated co-occurring substance use/mental health services. One day per week over the course of the rotation will be spent in didactic presentations, providing therapy to transrotational patients, and receiving supervision for transrotational cases. The substance use disorders rotation will be conducted at the Substance Abuse Rehabilitation Program (SARP) Portsmouth, which is located at Naval Medical Center, Bldg 104, 620 John Paul Jones Circle, Portsmouth VA, 23708-2197. SARP Portsmouth is an 80-bed substance abuse treatment facility that provides prevention, outpatient, intensive-outpatient, and intensive-outpatient with berthing substance abuse treatment to active duty military personnel and their adult family members. The work day typically starts at 0730 and ends at 1630 Monday through Thursday. On Friday, the workday typically starts at 0730 and ends at 1400.

There will be rotation-specific reading assignments, which are individualized based on training needs and the intern's specific interests. The Biopsychosocial and EthicsLiaison will be available to consult with intern and supervisor throughout the rotation.

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

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

- A sharing of the supervisor's background and clinical competencies germane to practice within the inpatient mental health arena.
- Specific instructions regarding operating procedures and clinical documentation guidelines that are specific to SARP.
- Opportunity to observe supervisor leading no fewer than three groups.
- Opportunity to observe supervisor consulting with interdisciplinary team members on no fewer than 5 occasions.
- Respect for cultural, biopsychosocial, and power differences within the supervisor-supervisee-patient triad.
- A relationship characterized by:
    - Open communication and two-way feedback.
    - The expectation that the intern will voice disagreements and differences of opinion.

  - Attention to personal factors, such as values, beliefs, biases, and predisposition. However, supervisor will not require intern to disclose personal information regarding sexual history, history of abuse, psychological treatment, and relationships with parents, peers, and spouses or significant others unless this information is necessary to evaluate or obtain assistance for the intern when it is judged that such issues are preventing the intern from performing his/her training or professionally related activities in a competent manner or the intern poses a threat to self or others.

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

The Supervisor may expect from _____(intern) the following:

- Adherence to clinic, ethical and legal codes and Navy policies, including use of a supplementary consent form indicating services are being provided by a psychology intern under the supervision of a licensed clinical psychologist.
- Use of standard clinical evaluation and report formats.
- Completion of all clinical documentation so that clinical entries into the electronic medical record will be made within 72 hours of service delivery.
- Maintenance of draft and final reports of all case materials within the intern's folder on the appropriate computer share drive.

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

- Performance Evaluation:

At the end of the substance use rotation competency ratings are made, independently, by the NMCP substance use supervisor and the intern's Transrotational supervisor as described in the Training Manual. Levels of competency development expected at the end of these rotations are outlined in the Competency Assessment Rating Scale, which is contained in the program's Training Manual. While end of rotation evaluations provide objective feedback as to the intern's progression toward completion of the internship, individual rotations are not "passed" or "failed" per se, nor are rotations repeated when performance is subpar. An intern obtaining ratings at or above "Acceptable" is considered to be in good standing in the training program. An intern whose competency ratings fall below the minimally acceptable level, as defined in the training manual, will be placed in a remedial status and provided with a remedial plan. Remedial plans target specific performance deficiencies and outline measures designed to assist the intern in over-coming performance/competency obstacles. If the remedial plan does not bring an intern up to expected competency levels by the next rating period, the intern may be given a second period of remediation or, conversely, at the recommendation of the Training Committee may be referred to the Graduate Medical Education Committee, which could result in the intern's placement on Command Probation. The intern's rights to due process are strictly maintained throughout this process.

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

Substance Use Supervisor

_____ Date: _____

Transrotational Supervisor

APPENDIX S

Health Psychology Rotation Contract

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

Health Psychology: Pain Psychology Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

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

The training program's goals, and thus this rotation's goals, are the development of professional competencies as a clinical psychologist. Performance at the end of this rotation will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document. From 60 to 70% of the rotation will be spent in direct clinical service and interdisciplinary activities. Treatment of chronic pain is a major focus of this rotation. The rotation will provide the intern the opportunity to work in collaboration with physiatrists, physical therapists, surgeons, and anesthesiologists. The intern will be supervised in the performance of assessments and interventions for the treatment of military personnel and family members who present with chronic pain conditions and co-morbid psychological distress. The intern will provide cognitive-behavioral individual and group therapy for chronic pain. The intern will also have the opportunity to provide consultation and (primarily) group interventions in other health psychology areas, such as insomnia, weight management, and TBI.
There will be rotation-specific reading assignments, which will be focused on the assessment and treatment of chronic pain. Additional readings will be individualized based on training needs and the intern's specific interests. The Biopsychosocial and EthicsLiaison will remain available to consult with intern and supervisor throughout the rotation.

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

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

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

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

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

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

Performance Evaluation:

The evaluation of competency attainment at the end of this rotation is performed by the pain psychology rotation supervisor and the intern's Transrotational supervisor, who comprise the intern's Competency Committee. Specific evaluation procedures are described in the Training Manual, along with the expected and minimally acceptable levels of competency development

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

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

Rotation Supervisor

_____ Date: _____

Second Rotation Supervisor

APPENDIX S

Child/Family Supervision Contract

SUPERVISION CONTRACT
2022-2023 CLINICAL
PSYCHOLOGY INTERNSHIP TRAINING PROGRAM
OUTPATIENT MENTAL HEALTH DEPARTMENT, PSYCHOLOGY DIVISION
NAVAL MEDICAL CENTER
PORTSMOUTH, VA

Child/Family Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

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

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

child and family resources are provided as appropriate. The intern will primarily be supervised by a child psychologist but may also have the opportunity to work with psychiatrists and licensed clinical social work staff.

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

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

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

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

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

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

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

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

Performance Evaluation:

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

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

Rotation Supervisor

_____ Date: _____

Second Rotation Supervisor

APPENDIX T

Neuropsychology Supervision Contract

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

Neuropsychology Rotation

Rotation Start Date: _____

Rotation Completion Date: On or about _____

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

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

- Clinical interview (Neuropsychological (medical-based) Interview)

- Test introduction and administration
- Report writing
- Clinical feedback

The intern will also have the opportunity to participate in interdisciplinary committees on an ad hoc basis. Additionally, interns may have the opportunity to observe a neurologist during one or more neurology outpatient clinical days.

There will be rotation-specific reading assignments, which will be focused on neuroanatomy and neuropsychological assessment. Additional readings will be individualized based on training needs and the intern's specific interests. The Biopsychosocial and EthicsLiaison will remain available to consult with intern and supervisor throughout the rotation.

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

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

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

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

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

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

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

Performance Evaluation:

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

Individual rotation goals are set via discussion between the intern 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):

_____

_____

_____

_____ Date: _____

Psychology Intern

_____ Date: _____

Rotation Supervisor

APPENDIX U

Transrotational Supervision Contract

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

Transrotational Therapy Supervision Contract

Start Date: _____

Completion Date: On or about _____

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

The training program's goals, and thus this training experience's goals, are the development of professional competencies as a clinical psychologist. While this training activity lasts the entire year (though you may elect to change supervisors after six months and enter into another supervision agreement for the remainder of the training year), performance will be evaluated relative to competency benchmarks as presented in the Competency Assessment Rating Scale and the Competency for Psychological Practice Benchmarks document at the end of each quarter when interns switch primary rotations. Over the course of the Transrotational Therapy training experience the intern will develop and exhibit clinical competencies by providing empirically validated psychological interventions to patients with various mental health conditions in an outpatient setting. The intern can expect to follow 1-4 therapy cases each week over the course of the training year under the supervision of his/her Transrotational supervisor. Cases are seen within the Child/Training Clinic in Building 3 on each Tuesday of the training year, along with participation in the didactics program, with the other four days of the week devoted to one of the four primary rotations. In addition, the Transrotational supervisor may assign specific readings based on the intern's training needs and specific interests.

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

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

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

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

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

Performance Evaluation:

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

Individual rotation goals are set via discussion between the intern 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):

_____
_____
_____

_____ Date: _____
Psychology Intern

_____ Date: _____
Transrotational Supervisor

APPENDIX V

Weekly Supervision Form

Intern Weekly Supervision Summary Form

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

Unscheduled Supervision

Day of Week	Face to Face Individual Hours	Face to Face Group Hours
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

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

____ Intern description of case
____ Supervisor's observation of assessment/ therapy session
____ Supervisor's observation of team/referral source consultation
____ Observation of Supervisor by intern
____ Observation of Adjunct Supervisor by intern
____ 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 SUPERVISION (Check all that were addressed)

1. ____*Research*
2. ____*Ethical/Legal Standards and Policy*
3. ____*Individual and Cultural Diversity*
4. ____*Professional values/attitudes/behaviors (includes professionalism and reflective practice)*
5. ____*Communication/interpersonal skills*
6. ____*Assessment*
7. ____*Intervention*
8. ____*Supervision*
9. ____*Consultation/interprofessional/interdisciplinary*
10. ____*Officer Development*
11. ____*Teaching*

POSITIVE FEEDBACK PROVIDED TO INTERN:
_____ No ____ Yes, as follows: _____

_____

CONSTRUCTIVE FEEDBACK PROVIDED TO INTERN:
____ No _____ Yes, as follows: _____

_____

ISSUES PRETAINING TO THE SUPERVISORY RELATIONSHIP DISCUSSED:
____ No ____ Yes, as follows: _____

_____

_____

Supervisor_____ Intern _____

APPENDIX W

Intern Didactic Evaluation Form

Intern Didactic Evaluation Form

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

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

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

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

INDICATE WHICH OF THE COMPETENCIES LISTED BELOW WERE ADDRESSED DURING THIS PRESENTATION, INDLUDING DISCUSSION BY ATTENDEES

1) ____ Research
2) _____ Ethical Legal Standards and Policy
3)_____ Individual and Cultural Diversity
4) _____ Professional values/ attitudes/behaviors
5) _____ Communication interpersonal skills
6) _____ Assessment
7) _____ Intervention
8) _____ Supervision
9) ____ Consultation/interprofessional/interdisciplinary
10)____ Teaching
11)____ Officer Development

APPENDIX Y

Intern's Evaluation of Supervisor

Intern's Evaluation of Supervisor for the _____ Rotation

Intern: _____
Supervisor: _____

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

NOTE: Please rate your supervisor on the following criteria.

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

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

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

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

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

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

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

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

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

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

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

Use the following rating scale: 1 = Poor

2 = Marginal

3 = Adequate

4 = Good

5 = Excellent

1) ____ Research

2) _____ Ethical Legal Standards and Policy

3)_____ Individual and Cultural Diversity

4) _____ Professional values/ attitudes/behaviors

5) _____ Communication interpersonal skills

6) _____ Assessment

7) _____ Intervention

8) _____ Supervision

9) ____ Consultation/interprofessional/interdiscipline

10)____ Teaching

11)____ Officer Development

Total:_____ (100%)

Additional Comments:

_____
_____
_____
_____
_____
_____

_____ _____

Intern Supervisor

APPENDIX Z

Intern's End of Year Evaluation of Program

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

Intern: _____
Date: _____

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

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

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

What were the best aspects of the application process?
_____
_____
_____

Where is improvement needed? _____
_____
_____
_____

General Comments: _____
_____

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

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

What were the best aspects of the orientation procedures?
_____
_____
_____

Where is improvement needed? _____
_____
_____
_____
_____

General Comments: _____

_____
_____

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

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

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

Where is improvement needed? _____
_____
_____

General Comments: _____
_____

4.) Overall, the Inpatient/Acute Care Rotation was (circle your response):

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

What were the best aspects of the Inpatient Psychiatry Rotation?
_____
_____

Where is improvement needed? _____
_____
_____

General Comments: _____
_____

6.) I completed the (circle one): Child/Family Neuropsychology Health/Pain rotation.
Overall, this rotation was (circle your response).

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

What were the best aspects of this rotation?
_____
_____

Where is improvement needed? _____

_____
_____

General Comments: _____
_____

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

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

What were the best aspects of the Transrotational Training Experience?
_____
_____

Where is improvement needed? _____
_____
_____
General Comments: _____
_____

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

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent N/A

What were the best aspects of this operational experience?
_____
_____

Where is improvement needed? _____
_____
_____

General Comments: _____
_____

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

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent N/A

What were the best aspects of this operational experience?
_____
_____

Where is improvement needed? _____

_____
_____

General Comments: _____
_____

11.) The Embassy Security Guard Selection experience (if applicable) was (circle your response):

1 = Poor 2 = Marginal 3 = Adequate 4 = Good 5 = Excellent N/A

What were the best aspects of this experience?
_____
_____
_____
_____

Where is improvement needed? _____
_____
_____

General Comments: _____
_____

12.) The Substance Addiction Rehabilitation Program experience was (circle your response):

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

What were the best aspects of the Substance Abuse experience?
_____
_____

Where is improvement needed? _____
_____
_____

General Comments: _____
_____

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

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

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

Where is improvement needed? _____
_____
_____
General Comments: _____
_____

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

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

List the best didactic presentations you received this year.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

What are your recommendations for improving the Didactics program?

_____
_____
_____
_____
_____

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

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

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

_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

What are your recommendations for improving opportunities for peer interaction?

_____
_____
_____
_____
_____
_____

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

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

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

_____
_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

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

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

_____
_____
_____
_____
_____
_____
_____
_____

Where is improvement needed? _____
_____
_____
_____
_____
_____
_____
_____
_____

General Comments: _____
_____
_____
_____

Now, please rate the program's ability to provide training as per the Competencies used to inform our training program.

Use the following rating scale: 1 = Poor

2 = Marginal

3 = Adequate

4 = Good

5 = Excellent

1) ____ Research

2) _____ Ethical Legal Standards and Policy

3)_____ Individual and Cultural Diversity

4) _____ Professional values/ attitudes/behaviors

5) _____ Communication interpersonal skills

6) _____ Assessment

7) _____ Intervention

8) _____ Supervision

9) ____ Consultation/interprofessional/interdiscipline

10)____ Teaching

11)____ Officer Development

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

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

_____ _____

Signature Date

Clinical Psychology Internship Training Program

APPENDIX AA

Application Form

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

Application for Training Year: Part 1

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

Personal Information

Name: Last/First, MI):

Other Names you have used:

Home Address:

Work Address:

Best Phone Number to reach you during the day:

Fax Number:

Email:

Graduate Program Information

Graduate Program Name:

Department Name:

University/Institution Name:

Training Director's Name:

Training Director's Telephone Number:

Training Director's Email:

Complete Mailing Address for contacting your Training Director:

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

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

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

No

Yes

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

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

No ☐

Yes ☐

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

Please complete the following table summarizing your clinical training experiences (i.e., clerkships, practica) since beginning graduate studies in clinical psychology. Please record separately hours spent providing services to adults and children, to include all supervision hours that reflect the hours of supervision for adult cases and hours of supervision for child cases.

Alternatively, you may submit another form of documentation (i.e. Time2Track™ , or PsyKey) that provides an accurate representation of your clinical training experience rather than recalculating your clinical training hours for this table.

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

Totals						

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

2025-2026 Training Year Individualized Training Plan Assessment

The Individualized Training Plan Assessment is submitted after acceptance to internship and is meant to serve as a springboard for the individualization of the intern's training plan. The program will engage in offering teaching that indicates respect for and understanding of cultural and individual differences to promote the provision of quality psychological services to all individuals. This document is oriented around the competencies around which the programs training aims, objectives and assessments are based upon. The program's profession-wide competencies include the following: Research, Ethical and legal standards, Individual and cultural diversity, Professional values, attitudes, and behaviors, Communication and interpersonal skills, Assessment, Intervention, Supervision, and Consultation and interprofessional/interdisciplinary skills. In addition the training program provides training opportunities and assesses interns within the program specific competencies of Teaching and Officer Development. Competency Benchmarks used in this program were originally developed 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*, and our assessment instruments parallel those recommended in the accompanying article, *Competency Assessment Toolkit for Professional Psychology* (Kaslow, Grus, Campbell, Fouad, Hatcher, & Rodolfa, 2009). As the program has grown and evolved we have continually updated our Competency Benchmarks, centered on program aims and guided by relevant literature and APA resources. We have found that these published resources offer our training program the best available guidance regarding the conceptualization and assessment of competence for the emerging psychological provider: Hatcher, Fouad; Grus, Campbell, McCutcheon, Leahy, Kerry L., May 2013. *Competency benchmarks: Practical steps toward a culture of competence.* Training and Education in Professional Psychology, Vol 7(2), 84-91; Price, Callahan, Cox, (2016). *Psychometric Investigation of Competency Benchmarks*. Training and Education in Professional Psychology, and http://www.apa.org/ed/graduate/benchmarks-evaluation-system.aspx/.
Below, each competency is described and then followed by the delineation of essential features and benchmarks corresponding to the "readiness for internship training" developmental level. These descriptions are followed by specific requests for information or questions for you to answer. Your responses should be comprehensive yet concise and to the point. If you have not fully addressed some of these competency areas up to this point in your training, you should refer to experiences you expect to have between now and the beginning of internship training that will address the relevant issues.

Profession-Wide Competencies

1. Research

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

Describe your experiences in conducting psychological research. Make sure you specify your role in any collaborative projects and list any presentations at professional meetings and/or publications.

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

Please describe your experiences to date in applying evidence-based practice to your clinical training activities. Indicate which evidence-based interventions you have used and the basis by which you have selected specific interventions over others. Additionally, indicate the total number of clients you have treated with an evidence-based procedure, the total hours spent providing this type of intervention, and the total number of hours received in supervision (specify individual and/or group supervision formats and indicate licensed/unlicensed status of supervisors).

2. Ethical Legal Standards and Policy: Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations. Advocating for the profession

Essential Component A. Knowledge of ethical, legal and professional standards and guidelines: Intermediate level knowledge and understanding of the APA Ethical Principles and Code of Conduct and other relevant ethical/professional codes, standards and guidelines; laws, statutes, rules, regulations

Behavioral Anchor: Identifies ethical dilemmas effectively; Actively consults with supervisor to act upon ethical and legal aspects of practice; Addresses ethical and legal aspects

within the case conceptualization; Discusses ethical implications of professional work; Recognizes and discusses limits of own ethical and legal knowledge

Describe the process or model you use to resolve ethical dilemmas and then the application **of such to an ethical dilemma that arose during some aspect of your clinical training.**

3. 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.

Describe the range of diversity of your patients.

Describe a situation where diversity impacted assessment or treatment.

4.

Professional values, attitudes, and behaviors

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

Please describe the most important experiences you have had that have impacted your sense of professionalism.

Reflective Practice/Self-Assessment/Self-Care: Practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and a commitment for the development of the profession.

Please describe clinical training and educational experiences to date that have prepared you to engage in reflective practice, self-assessment, and self-care, as outlined above.

5. Relationships: Relate effectively and meaningfully with individuals, groups, and/or communities

Describe your ability to negotiate differences and handle conflict. Additionally, describe your manner of giving feedback to others and your ability to receive such. Cite specific examples to illustrate your points.

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

List the clinical tests you have administered, along with the number of administrations. Also report the extent to which you were observed by a supervisor during test administration.

Discuss the extent to which you have received formal coursework addressing the DSM-5.

How many psychological reports containing test data have you completed? List the 5 most frequent diagnostic groups for whom you have provided test data. What aspect of your report writing has been given the greatest emphasis during supervision?

7. Intervention

State your theoretical orientation to therapy. Describe the extent of your training in this model, including formal coursework, workshop/didactic trainings, and clinical supervision specifically linked to this theoretical model. Delineate the number of hours spent performing interventions accordingly to this model and the number of supervision hours received in support of this intervention (specify individual or group supervision). Also describe the extent to which you have: 1) observed supervisors performing this model of therapy either live or via video/audio recording, and 2) the extent to which you have been directly observed performing this intervention by supervisors.

Describe your approach to developing rapport with clients and your approach to forming therapeutic relationships.

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

Describe the extent to which you have functioned in a supervisory role up to this point in your training as a psychologist. Include experience in peer supervision as well as experiences supervising technicians or persons falling below your developmental level as a psychologist.

Describe a specific instance where you identified an ethical or legal issue and brought it to your supervisor's attention. Describe how the issue was resolved.

9. Consultation and interprofessional/interdisciplinary skills

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

Describe your experiences to date of providing feedback to consultees—may reference clinical or nonclinical consultation services.

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

Essential Component A. Knowledge of the shared and distinctive contributions of other professions: Awareness of multiple and differing worldviews, roles, professional standards, and contributions across contexts and systems, intermediate-level knowledge of common and distinctive roles of other professionals

Behavioral Anchor: reports observations of commonality and differences among professional roles, values, and standards

Describe the range of other professions with which you have worked. Outline your understanding of the commonalities and differences among these professions.

Describe a particular clinical case in which your ability to provide interdisciplinary collaboration/consultation enhanced outcome.

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

Describe a clinical case for which you served as an advocate for one of your patients.

Program-Specific Competencies

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

Describe your experiences in the area of teaching and, in particular, provide examples of innovative/creative approaches you have taken.

2. Officer Development: Encompasses the concept of officership (i.e. criteria beyond professionalism as it pertains to being a uniformed services officer). Qualities of officership, and knowledge of uniformed service protocol, service standards, cultural and social etiquette have critical importance for commissioned Navy officers.

Describe your development as an officer thus far (we recognize some applicants will have had more limited opportunities in this area). Describe your involvement in organizations related to the practice of military psychology.

APPENDIX BB

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 biopsychosocial variables?

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 CC

End of Year Learning Climate Survey

End of Year Learning Climate Survey

Faculty Attitudes: Biopsychosocial and Ethics

1. Training faculty modeled respectful attitudes toward biopsychosocial variables.
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.

APPENDIX DD

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				Period of Report	
10. Periodic ☐	11. Detachment of Individual ☐	12. Detachment of Reporting Senior ☐	13. Special ☐	14. From:	15. To:

16. Not Observed Report ☐	Type of Report			20. Physical Readiness	21. Billet Subcategory (if any)
	17. Regular ☐	18. Concurrent ☐	19. OpsCdr ☐		

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	2.0 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	☒	0	0	1	1	6	

45. Signature of Reporting Senior

Date:

Member Trait Average: 0.00 Summary Group Average: 3.58

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:

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 EE
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.

1

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.MATTHEW.JOSEPH.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

TSCHANZ.MARK.PETER.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

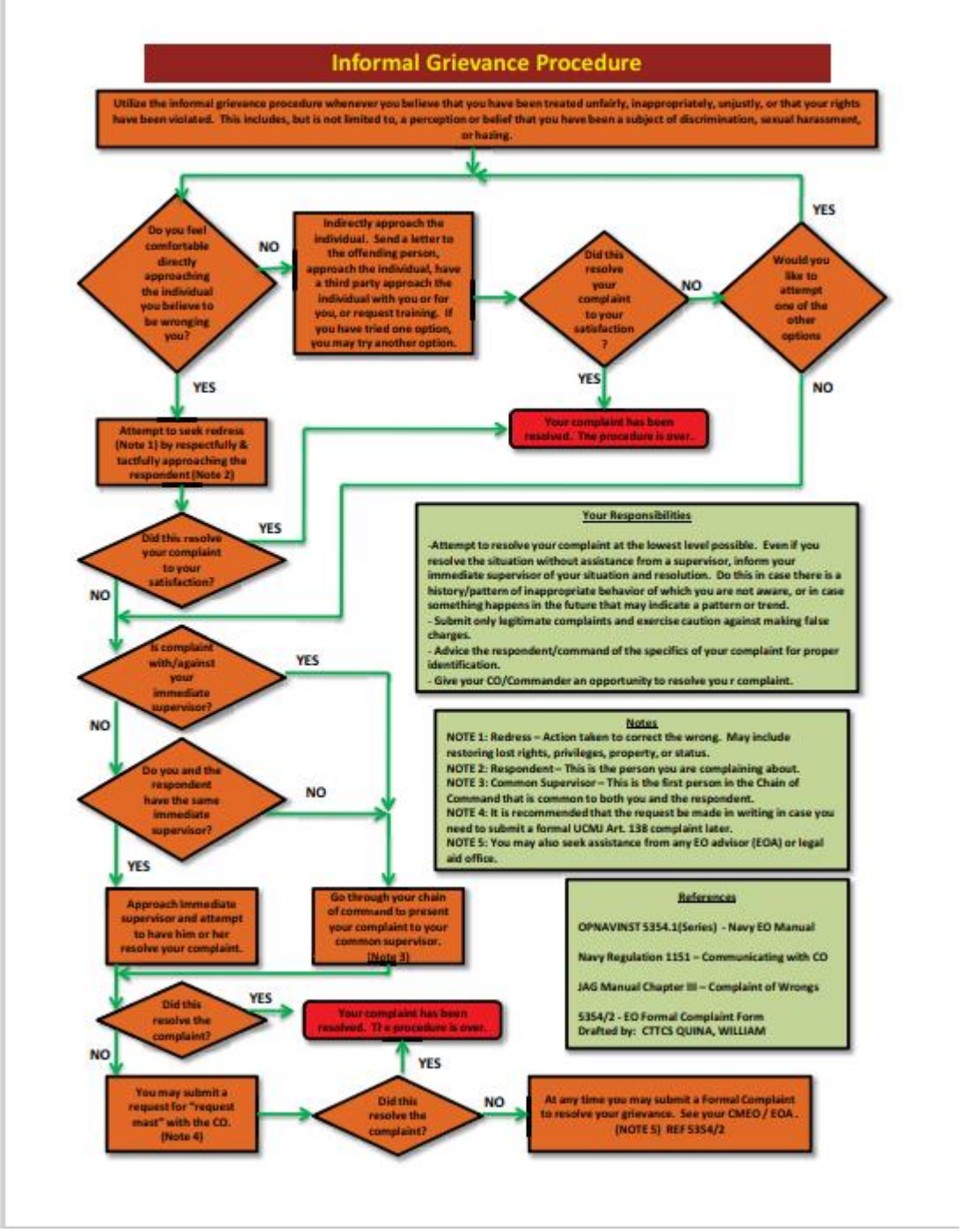
Appendix FF

Command Equal Opportunity Program

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

Appendix GG

Informal Grievance Procedure



Appendix HHF

Formal Grievance Procedure