NAVY CLINICAL PSYCHOLOGY INTERNSHIP PROGRAM TRAINING MANUAL

Revised 01 AUG 2016

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PREFACE

The following Manual provides a detailed description of the principles, aims, and competencies of the Navy Clinical Psychology Internship Program at the Walter Reed National Military Medical Center, one of three Navy Clinical Psychology Internships. The other Navy Internship sites are located at the Naval Medical Center, San Diego, CA, and the Naval Medical Center, Portsmouth, VA. Only the internship programs at Walter Reed National Military Medical Center and Naval Medical Center San Diego participate in the Association of Psychology Post-Doctoral and Internship Centers (APPIC) Match. Applicants have the option of applying to one or both sites. Applications are reviewed by a single Navy Selection Board. Matches are dependent on the rankings of applicants made by the Selection Board and by the rankings of the Navy sites made by the applicants. It is important for the applicant to acquire sufficient information about both sites so that informed rankings can be made. Any resulting APPIC Match with a Navy internship will be with one specific internship site.

Applications for the Navy Clinical Psychology Internship Programs have two parts:
1) the standard application and supporting documents submitted for the APPIC Match, and 2) the information needed to establish the applicant's qualifications to be commissioned as a naval officer. The second part of the application MUST be completed with the assistance of a Navy Medical Programs Officer Recruiter (see Appendix A for additional information).

The Navy internship sites do not function as a formal Consortium as defined by the American Psychological Association, although their programs are similar and they work in cooperation with one another.

The Navy internship sites will make a reasonable effort to share address lists of persons who write requesting information from any particular site. However, it remains the responsibility of the applicant to seek out the information he/she needs to make informed decisions.

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OVERVIEW

The Clinical Psychology Internship Program is sponsored by the Department of Behavioral Health Consultation and Education at the Walter Reed National Military Medical Center (WRNMMC), Bethesda, Maryland. It is fully accredited by the American Psychological Association (APA). The program is an intensive twelve-month period of clinical and didactic experiences designed to meet three broad aims: 1) To provide the trainee with experiences and skills needed to function competently as a broadly-trained clinical psychologist, 2) to equip the intern with additional knowledge and skills needed to practice competently within the Navy (e.g., unique military populations, personnel evaluation skills, etc.), and 3) To meet the overall requirements for continued accreditation as established by the APA in its Commission on Accreditation publications.

The internship is organized around a **Practitioner-Scholar** model. Day-to-day training emphasizes a sequential increase of knowledge and skill based on the current and evolving body of general knowledge and methods in the science and practice of psychology. Although active participation in research is not required as part of the internship, we expect interns to consistently refer to the psychology literature, and to be able to practically apply empirically supported interventions in their clinical work.

Before starting the internship, applicants who match with the internship are commissioned as Lieutenants in the United States Navy Medical Service Corps. During the internship (and subsequent service as active duty Navy psychologists), interns receive full pay and benefits as Navy officers. At the time of this writing, a new Navy Lieutenant assigned to Walter Reed National Military Medical Center receives an annual salary ranging from $80,604 to $83,004 (base pay + housing allowance for the Washington DC metro area). Annual pay raises occur as determined by the U.S. Congress and the military pay schedule.

The internship has been continuously accredited for over 50 years by the American Psychological Association's Commission on Accreditation. The program is scheduled for its next site visit in 2018.

Questions related to the program's accreditation status should be directed to the Commission on Accreditation:

Office of Program Consultation and Accreditation
American Psychological Association
750 First Street, N.E.
Washington, D.C., 20002-4242
(202) 336-5979 E-mail: apaaccred@apa.org Web: www.apa.org/ed/accreditation

APPIC Special Notice: This Internship Program has been a Member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) since APPIC's founding in 1990, and conducts intern selection in accordance with the policies and procedures of APPIC. This internship site agrees to abide by the APPIC Policy that no person at this training facility will solicit, accept, or use any ranking-related information from any intern applicant prior to Uniform Notification Day.

Navy Psychology Training and Practice:

Since few of our interns have had prior military experience, all attend the five week Officer Development School at Newport, Rhode Island prior to arrival at an internship site. This school 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.

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 faculty has identified, and continues to develop, learning experiences aimed at imparting the skills necessary for effective professional performance at the next Navy assignment. These experiences are organized into a dynamic curriculum which embodies the principles set forth in the current Standards of Accreditation of the American Psychological Association.

There are a number of ways in which the general professional skills imparted through the internship can be operationally described. The Navy Clinical Psychology Internship Program at Walter Reed National Military Medical Center has adopted the profession-wide competencies outlined in APA's Standards of Accreditation (2015) to include competencies related to: research; ethical and legal standards; individual and cultural diversity, professional values, attitudes, and behaviors; communication and interpersonal skills; assessment; intervention; supervision; and consultation.

The experiential clinical activities reflect the major areas in which military clinical psychologists may provide clinical services: Adult Outpatient Behavioral Health, Health Psychology (to include integrated behavioral health services in a primary care setting), Inpatient assessment and intervention, and Psycho-diagnostic Assessment. The profession-wide and program-specific competencies can be found in Appendix B.

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. Once licensed, they are able to be credentialed as a Licensed Independent Provider by the commanding officer of the medical facility to which he or she is 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. To reward this process of

professional development, the Navy pays all Board Examination fees, and pays an annual salary bonus to its Board Certified Psychologists.

PROGRAM DESCRIPTION (GENERAL)

The internship at Walter Reed National Military Medical Center is comprised of an orientation period followed by two 16-week rotations (Adult Outpatient Behavioral Health and Psycho-diagnostic Assessment), two 8-week rotations (Behavioral Health in Primary Care/Behavioral Sleep Medicine and Inpatient assessment and intervention), the overarching trans-rotation experience which is 12 months, operational training trips, and didactic presentations to include the Psychiatry Grand Rounds series and other military-specific didactic training.

Interns receive training from the Center for Deployment Psychology (CDP), associated with the Uniformed Services University of the Health Sciences in Bethesda, MD. CDP courses provide extensive training in aspects of the military deployment cycle, including situational and clinical factors impacting both deploying military members and their families. Additionally, CDP provides training in empirically supported treatment (either Prolonged Exposure or Cognitive Processing Therapy) for Post-Traumatic Stress Disorder, and Cognitive Behavioral Therapy for Insomnia.

Didactic training during the internship includes lectures, seminars, and Psychiatry Grand Rounds, sequenced in order to build on the training already received in graduate studies. Didactics include topics relevant to the general practice of clinical psychology (including professional ethics and cultural diversity), topics more specific to the practice of clinical psychology in the military, and ongoing education related to professional development as a Navy psychologist and naval officer.

Training trips include, whenever possible, approximately one week providing psychological services aboard a major Navy combat vessel at sea, giving the interns a firsthand overview of life and clinical issues in the Navy Fleet. Additionally, interns will visit either Marine Corps Base Quantico, VA or Marine Corps Base Camp Lejeune, NC to observe training and health service delivery in a Marine Corps context.

Walter Reed National Military Medical Center, the largest tertiary care hospital in the Military Health System, offers a full range of administrative assistance opportunities. Interns have identified office space and are provided with laptop computers. The Medical Center's medical library includes a range of journals, books, and electronic search capabilities related to the practice of psychology, as well as staff assistance with online literature searches.

PROGRAM DESCRIPTION (SPECIFIC)

The program described below is planned for year 2016-17:

I. Orientation

The orientation period includes the first two weeks of the internship and covers such topics as departmental structure, standard operating procedures, a tour of the hospital, rotational competencies, preparing individual development plans, the importance of dissertation completion, seminar scheduling, office assignments, etc. As with every other newly reporting staff member, the intern will spend a full week during the first month attending hospital orientation and will attend training on the military electronic health record for clinical documentation.

II. Clinical Rotations

A. Adult Outpatient Rotation (16 Weeks): The Outpatient Rotation offers interns the opportunity to develop the necessary competencies that they will require to provide appropriate care in hospital and operational environments. These opportunities include experience with a variety of general mental health evaluations, military-specific evaluations, and experience in providing psychotherapy. Military evaluations include: Command Directed Mental Health Evaluations, Deployment Screenings, plus evaluations for: Drill Sergeant, Fitness for Duty, Sniper, Recruiter, Security, and Temporary Disability and Retirement. Additionally, the intern will co-facilitate a therapy group and participate in at least one couple's therapy case during the rotation. Interns will learn how to assess and manage risk for self-directed and other-directed aggression, as well as learn how and when to refer patients to more intensive or controlled treatment environments. Interns will gain experience communicating with military commands regarding Service member's performance and fitness for duty. Didactic experiences include reading and discussion related to military-specific issues as well as profession-wide competencies. The residents will also gain experience in managing their appointment template and in the logistics of administrative management in an outpatient clinic.

B. Psycho-Diagnostic Assessment Rotation (16 Weeks): The Psycho- Diagnostic Assessment Service at WRNMMC receives testing referrals from the Inpatient Psychiatry Service, the Psychiatry Continuity Service, the Trauma Recovery Program, the Adult Behavioral Health Clinic at WRMMMC as well as from other Military Treatment Facilities within the National Capital Area. The training goals of this rotation include; familiarizing the Navy interns with the most frequently used psychological assessment measures in Navy and other military settings, developing an understanding of the administration and interpretation of these measures, as well as gaining experience working in a consultation role within a medical system. Interns attend weekly individual and group supervision, as well as a didactic seminar. Group supervision is also, along with the didactic seminar, an opportunity to review test construction, validity and reliability issues, as well as current literature on tests such as the MMPI-2, MMPI-2RF, the MCMI-III, and other commonly used measures. In addition, we do spend some time reviewing the new RPAS Rorschach system.

While on the Assessment Service, interns also participate in a brief rotation with the Psychiatric Consultation and Liaison Service where they assist in covering emergency room evaluations. Crisis management skills, along with risk assessment are the critical learning objectives of this experience. In addition, interns gain experience working on a multidisciplinary clinical team.

C. Health Psychology/Behavioral Sleep Medicine Rotation (8 Weeks): During this rotation interns work in the Primary Care clinic for eight weeks practicing a collaborative population health approach to behavioral health. Interns serve as consultants to primary care providers who rapidly evaluate patients' symptoms and functioning. Interns address patients' needs with regard to chronic health conditions and behavioral health conditions. They also increase motivation for behavioral change, provide brief, targeted interventions and dispositional recommendations. Problems addressed include headaches, pain, anxiety, insomnia, weight reduction, treatment adherence, and lifestyle management. Integrated throughout the 8 week rotation is an opportunity to learn about Behavioral Sleep Medicine (BSM). Interns will be trained in Cognitive Behavioral Therapy for Insomnia and other topics in BSM. Interns will have the opportunity to consult with providers in the Sleep Disorders Center on the treatment of patients.

D. Inpatient Rotation (8 Weeks): Interns will have the opportunity to spend one month each on the Inpatient Psychiatry Service and the Inpatient Neurobehavioral Service.

While rotating on the Inpatient Psychiatry Service, interns will become acquainted with the admission, diagnosis, acute stabilization, treatment and disposition of patients with mental health disorders of such severity as to require hospitalization. The intern is part of a multidisciplinary treatment team (comprised of staff psychiatrists and psychologists, psychiatric residents, nurses, social workers and hospital corps staff) and will be responsible for individual therapy, group therapy and consultation.

During the four weeks on the Inpatient Neurobehavioral Service, interns will have the opportunity to function within a unique multi-disciplinary setting (neuropsychiatry, psychiatry, psychology, neuropsychology, nursing, social work; physical, speech, occupation and recreational therapy) - providing consultation and individual and group therapy to inpatients with various neurobehavioral disturbances secondary to a brain injury. Interns will gain an understanding of the role of psychology in treating brain injury as well as how to understand and address the neuropsychiatric complications of brain injury.

Throughout the eight weeks, interns will spend one day a week focusing on gaining an understanding of basic elements in cognitive evaluation, having an opportunity to evaluate inpatients with a variety of neurological complaints. By the end of the rotation, interns will be able to accurately diagnose traumatic brain injuries, perform basic cognitive screening evaluations, decide when a referral to a neurologist or neuropsychologist is indicated, and understand how to critically read neuropsychological reports.

E. Trans-rotational Requirements: In addition to the basic requirements expected of the intern to meet the goals of the major rotations, the following trans-rotational objectives are required.

- **Long-Term Individual Therapy Case:** Each intern is expected to carry one long-term, psychodynamic outpatient case during the year (long- term means at least 9 months). The Training Director will coordinate the assignment of long-term cases and ensure weekly supervision is provided.
- **Combat Trauma Cases:** Each intern is expected to carry cases of patients suffering from Post-Traumatic Stress Disorder (PTSD). Whenever possible, a case will be treated to completion before the next is begun.

Interns are given the opportunity to learn a variety of evidence-based therapies for PTSD with a principle focus on Prolonged Exposure and Cognitive Processing Therapy. All of the cases may be supervised by the same supervisor or different supervisors, depending on the model used and the expertise of the supervisor.

- **Operational Psychology Seminar:** This seminar is an informal facilitated discussion with senior Navy Psychologists from Department of the Navy communities (Marine Corps, Navy Air, Submarine, Surface, Navy Special Warfare). Interns receive information about the different assignments and duties Navy psychologists can perform outside of the traditional mental health setting. Topics address military-specific competencies to include discussions about military culture, military-specific psychological evaluations, and exposure to Navy and Marine Corps mental health policies and instructions.

III. Clinical Didactic Training Presentations:

A program of scheduled and sequenced seminars and other workshop presentations accompanies the intensive direct supervision on the clinical rotations. These didactic presentations are designed to expose the intern to contemporary information and training relevant to the practice of behavioral health, both as a clinical psychologist and as a Navy psychologist. The faculty, the presenter, and the level of interest of the attendees determine the particular format for a topic and the amount of time devoted to it. The presenters of these didactic programs frequently are distinguished colleagues from the Navy and civilian clinical/academic communities. Interns are also required to attend weekly Psychiatry Grand Rounds and periodic special training opportunities lasting a full day or longer.

IV. Operational Experiences:

A. The major operational experience is a deployment, lasting approximately one week, aboard a major Navy combat vessel during which the interns will experience shipboard living conditions and stresses, work in the ship's Medical Department, interact with sailors, and learn about the industrial and psychological demands of working and living aboard a large ship. This deployment is typically aboard a US Navy aircraft carrier, under the guidance and supervision of the Navy Psychologist assigned to the carrier. In rare circumstances where the ship has no psychologist on board, a uniformed and experienced member of our Internship faculty will accompany interns to supervise their professional work and guide their experiential education.

B. When possible, a second operational experience is scheduled with the Second Marine Division or the Marine Special Operations Command, both at Camp Le Jeune, NC, and/or with Marine Security Group (MSG) at Marine Corps Base Quantico, VA. Particular emphasis is placed on gaining familiarity with the operational plans and stresses unique to the Marine Corps, and on developing skills for effective consultation with Marine Corps Commands.

V. Additional Intern Functions and Roles:

A. Class Adjutant: Each intern will function as the class adjutant on a rotating basis. As such, the intern serves as the senior member of the class and as a liaison for information between leadership, faculty, and intern. Specific responsibilities include the following:

- For the seminar series, the adjutant is responsible for attendance forms, lecture evaluation forms, continuing education forms for staff, and equipment needed by the presenter. The adjutant conveys weekly seminar information to interns at military, civilian, and Veterans Administration internships in the local area.

- Organize all paperwork and travel for operational activities for internship class.

- Maintain an email and phone list for Air Force, Army, civilian and Veterans Administration Interns.

B. Medical Service Corps: All Navy psychology interns are officers in the Navy Medical Service Corps (MSC), and are strongly encouraged to interact professionally and socially with other MSC officers assigned to the hospital. Such interaction is not only important to the smooth and effective performance of the psychologist's job when it extends beyond the mental health clinic, but also serves to increase the intern's appreciation for other non-physician specialists in the Navy health care system, just as it increases others' awareness of the psychologist's role.

VI. Supervisors:

A. Most of the ongoing case supervision will be provided by designated privileged staff psychologists on the rotation to which the intern is assigned. Privileged psychiatrists serve as adjunct supervisors and provide additional supervision, particularly on the Psychiatric Consultation Liaison Service (PCLS) and Inpatient Rotations.

B. The intern may be assigned several staff members to supervise trans-rotational cases. Over the course of the year, the intern may receive supervision from several of the psychology faculty and some of the psychiatry staff. It is very important to note that in addition to scheduled supervision times, the faculty is available for and strongly encourages additional supervision and consultation as needed.

TRAINING AIMS

OVERALL TRAINING AIMS: As mentioned previously, the program's training aims are to provide the trainee with experiences and skills needed to function competently as a broadly-trained clinical psychologist, and to equip the intern with additional knowledge and skills needed to practice competently within the Navy. We identify and evaluate a set of profession-wide and program-specific competencies to ensure we are meeting our broad training aims. By the end of the internship year, interns are expected to demonstrate competencies in the following clinical skills: individual and group psychotherapy (both brief and long term), psychological assessment by interview and by testing, emergent and urgent evaluation as a member of the Psychiatry Consult Liaison Service, interdisciplinary

consultation with other healthcare providers, providing consultation to other healthcare providers, providing clinical consultation to active duty military commanders, basic cognitive assessment and referral, inpatient assessment and intervention, integrated behavioral healthcare in a primary care setting, and behavioral sleep evaluation and treatment. Additionally, when possible, interns will demonstrate basic competence in providing clinical supervision to other students, and a basic understanding of program evaluation. Competence in each of these areas at a level considered appropriate for initial licensure as a psychologist is the expected minimum standard of achievement. Interns will demonstrate that their work with each of these competencies is informed by the theoretical and research literature in psychology, is sensitive to multicultural factors impacting all aspects of clinical practice, and by the ethics of our profession.

Please see sample competency evaluation forms in Appendix B for an example of defined behavioral anchors for each competency.

GENERAL BEHAVIORAL CHARACTERISTICS EXPECTED OF INTERNS

- Willingness to learn
- Efficiency in work organization
- Assumption of responsibility
- Military bearing and appearance
- Creative problem-solving

EVALUATION

The evaluation process has two components: Measures of Intern Performance, and Evaluation of the Internship Program.

I. Intern Performance Evaluation

A. Weekly supervision. Throughout the internship year, the intern receives weekly scheduled and, when needed, unscheduled supervision. Each intern will receive at minimum four hours of scheduled supervision per week, at least two of which must be individual supervision. In addition to addressing clinical issues, case load, and professional growth, supervision is also a time for the primary supervisor to review intern progress toward program-specific and profession-wide competencies. At mid-rotation the intern and primary supervisor will have a formal session to review progress toward mastering clinical competencies and identify areas to be focused on during the second half of the rotation.

B. End of Rotation Competency Evaluation. The evaluation form (Appendix B) is submitted to the Program Director by the intern's primary supervisor at the mid-point and end of each 16-week rotation (formal evaluations for 8-week rotations occur only at the end of the rotation, with informal evaluation provided at the mid-point). At the time of the evaluation, there is a meeting between the rotation supervisor and the intern to review performance, and to discuss areas to be focused on in upcoming rotations. The Program Director can attend this meeting if desired by the intern or supervisor, but this is not required. Mid-point and end of rotation competency evaluations are the primary means of determining "passing" of rotations and successful internship completion. Each competency

is rated on a 5 point scale: “R”(Remedial Work Required), “E” (Entry Level), “I” (Intermediate Level), “P” (Proficient), and “A” (Advanced). In order to pass a rotation, an intern must achieve a rating of “I” or higher on all competencies. If an intern has any competency rated “R” (Remedial Work Required) or “E” (Entry Level) for an extended period of time, a remediation plan will be implemented to assist the intern in acquiring the identified competency. In some cases, this may involve repeating the rotation. All rotations must be passed to complete the internship. This could require extension of the internship past one year in order to achieve successful completion.

C. Navy Fitness Report. All Navy officers receive annual Fitness Reports, an evaluation of their performance both in their areas of specialization and, more generally, regarding their leadership abilities, team work, etc. These reports are prepared by the Program Director and forwarded to Senior Navy leadership for review and signature.

II. Internship Program Evaluation

At the mid-point and end of the internship year, each intern will submit a written evaluation of the training program to the Program Director. This report discusses both specific aspects of each rotation, as well as an overall assessment of the training program’s success in preparing the intern for future work in psychology. Additionally, at the end of each rotation, interns are required to submit an evaluation highlighting strengths of the rotation and supervision, along with suggestions for improving the rotation.

FACULTY SUPERVISION OF INTERNS

Rotation Supervision:

During the Psychology Internship each intern rotates through the aforementioned clinical rotations. While assigned to a rotation, the intern’s clinical work is supervised by a licensed independent provider. All documentation written by an intern is reviewed and signed by the responsible supervisor. High-risk patients (those with significant suicidal or homicidal ideation/plans/threats, or unable to adequately care for themselves) are to be discussed with supervisors and documented PRIOR TO departure of the patient from the clinic or service.

Trans-rotational Supervision:

Each intern is assigned multiple cases to be seen across rotations. Interns will be assigned a faculty supervisor who is responsible for supervising the evaluation, treatment, and documentation for trans-rotational cases. Supervision for trans-rotational cases will be scheduled, although unscheduled supervision for urgent or emergent issues is always available. As stated above, high-risk patients are to be discussed with supervisors and documented PRIOR TO departure of the patient from the clinic or service.

IN-PROGRAM REMEDIATION OF PSYCHOLOGY INTERN PERFORMANCE: A PROCEDURAL OUTLINE FOR DUE PROCESS MANAGEMENT

Introduction: It is the goal of the Navy Clinical Psychology Internship Program to educate and graduate 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 in order to develop a thoughtful and comprehensive plan for remediation.

Additionally, it is the intent of this policy to separate failure to learn from disciplinary matters. The latter is handled through the WRNMMC chain of command, the Director, WRNMMC, and the Commanding Officer, Navy Element, WRNMMC and may result in formal counseling statements, letters of reprimand, or even non-judicial punishment under the Uniform Code of Military Justice. On the other hand, 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, consistent with policy directives from the WRNMMC Professional Education Training Committee (PETC).

1. Acceptable levels of performance on each rotation are established. (See Competency Evaluation forms in Appendix B)

2. Performance criteria will be provided to each intern at the beginning of the internship year via a copy of this Training Manual.

3. The rotation's supervising psychologist will meet with the intern individually for at least two hours weekly. The supervisor will provide verbal feedback outlining the performance against the criteria.

4. Mid-rotation and end-of-rotation evaluations are forwarded by the rotation supervisor to the Program Director and are discussed with the intern.

5. In order to meet internship requirements, all rotations must be satisfactorily completed. Failure to meet criteria satisfactorily for one rotation does not necessarily exclude the intern from the next rotation, but may delay the scheduled graduation from the internship.

6. If unsatisfactory progress is determined by the Program Director, the intern will be placed on a written in-program remediation plan which the intern will be able to review and sign. (Remediation plan for one rotation may continue while the intern is on another rotation.) The Program Director will outline in writing the deficiencies and suggest methods and objectives to regain satisfactory status. A Review will be held 30 days, and then 60 days (if necessary) following the original notification of Remediation Plan (or more frequently if deemed appropriate). Once standards are met, remediation status will be removed, and the intern will be in good standing within the internship.

7. If the intern fails to meet the criteria necessary for removal from the remediation plan, the Program Director shall place the intern on probationary status and inform the appropriate Department Chief and the WRNMMC Professional Education Training Committee (PETC) of the intern's probationary status. The Program Director shall advise the intern in writing of this decision, detailing those areas of deficiency which could lead to termination of training, and establish a "cautionary period" of time (not more than 60 days, or the original ending date of the internship, whichever comes first) within which time the deficiencies must be brought up to acceptable levels.

A. The intern has the right to address the Program Director concerning his/her probationary status and performance.

8. After the designated cautionary period of probation has been completed:

A. IF PROGRESS IS SATISFACTORY, the intern's good standing is restored by a letter from the Program Director

B. IF INTERN PERFORMANCE DOES NOT IMPROVE TO A SATISFACTORY LEVEL, a request will be made to the WRNMMC PETC for action. It should be recognized that the Medical Center Director, upon the recommendation of the PETC, has the ultimate authority by regulation to make decisions regarding dismissal from the Training Program.

PROCEDURE FOR INTERN GRIEVANCES

If an intern finds him/herself with a grievance toward the training program, Program Director, or a faculty member, the grievance procedures are as follows:

1. In accordance with conflict resolution research, the APA ethical code, and general principles of human resource management, the intern should first attempt to communicate the grievance as clearly and specifically as possible to the party perceived as the source of the problem, either verbally or in writing.

2. In the event that an intern has a grievance with a faculty member or another supervisor, the intern should initially attempt to resolve the issue with the faculty member or supervisor concerned. If the intern cannot resolve the grievance with the individual involved, the matter is brought to the attention of the Program Director. The Program Director reviews the matter with the intern in order to clarify the issues. The Program Director attempts to resolve the grievance informally by discussing the issue with the faculty member or supervisor involved. If the grievance cannot be resolved informally, the Program Director reviews the matter with the Chief, Behavioral Health Consultation and Education (or the Professional Education Training Committee (PETC) if the issue is with the department chain of command), and subsequently makes appropriate recommendations for resolving the issue. If grievances continue, and are found to be legitimate, the matter will continue to be addressed by the Program Director and Chief, Behavioral Health Consultation and Education, in consultation with the PETC, until resolution is achieved. If the grievance is with the Program Director, the intern should

initially attempt to resolve the issue with the Program Director. If the intern cannot resolve the issue informally with the Program Director, the issue will be brought to the attention of the Chief, Behavioral Health Consultation and Education, who makes appropriate recommendations for resolving the issue.

3. If these informal channels fail to bring a resolution that is satisfactory to the intern, the next step in the process would be for the intern to make a formal complaint to the PETC. This body will review the complaint and the documentation of attempts to deal with the problem on the local level. The PETC will make a formal determination and inform all parties of the results and recommendations.

4. Information for equal opportunity complaints (SECNAV INSTRUCTION 5354.2), Navy Equal Opportunity policy (OPNAV INSTRUCTION 5354.1F) or sexual harassment complaints (SECNAV INSTRUCTION 5300.26D) are available online at the Navy Bureau of Personnel website (http://www.public.navy.mil/bupers-npc). A hard copy can also be obtained from the Officer in Charge, Navy Element, WRNMMC. 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 or safehelpline.org.

POLICY ON INTERN MILITARY LEAVE (VACATION)

I. The following guidelines have been developed to help faculty evaluate requests by psychology interns for time away from the internship. 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 the Rotation Director and the Program Director.

A. With rare exceptions under special circumstances, no more than five working days personal leave will be permitted during the internship year.

1. In addition to the above (and per MILPERSMAN 1320-210), no more than five consecutive days of no-cost temporary additional duty (TAD) for the purpose of obtaining housing at a new station will be allowed.

B. Two leave periods should not normally be requested during the same rotation. This implies that if a request for house hunting is going to be made during the last rotation, other requests should be planned in earlier training periods, if possible.

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

D. Consideration of additional time away, such as time for meeting with dissertation committees or defending dissertations will be on a case-by-case basis.

PSYCHOLOGY INTERNSHIP DIDACTIC PRESENTATION SERIES

I. The purpose of the series is to provide the psychology interns with didactic training in areas relevant to the practice of clinical psychology generally, and Navy psychology specifically. Didactic training includes a Psychiatry Grand Rounds series, scheduled on Wednesdays from 1600-1700. Additional didactic trainings will be scheduled on Friday afternoons from 1300-1530. Friday afternoon didactics occur once or twice a month. Navy Psychology interns meet weekly with the Training Director, during which administrative issues are covered, journal articles are discussed (focusing on Leadership, Ethics and Multicultural Competence), and prepared case presentations made and discussed.

The following principles have been established for the various didactic training series:

A. Each presentation is practice oriented.

B. The interns will be exempted from scheduled clinical responsibilities during the planned didactic seminars. Any exception must be cleared with the Rotation Director and Program Director.

C. For interns, attendance is mandatory, unless time away has been approved by the Program Director in advance. Clinical responsibilities should be scheduled so as not to be a reason for absence.

Following each presentation, those attending will complete an evaluation form.

Examples of Recent Seminars, Grand Rounds, and Extended Training Topics

Cognitive Processing Therapy (two day course)
Prolonged Exposure Therapy (two day course)
Case Formulation and Presentation
Program Evaluation
Military Specific Psychological Evaluations
Cognitive Behavioral Therapy for Insomnia
Ethics and Professional Practice in Psychology
Ethics and Professional Practice in a Deployed Setting
Licensure, Board Certification, and Other Credentials in Psychology
Traumatic Brain Injury
Psychological Practice with Lesbian, Gay, and Bisexual Clients
Diversity: Experiencing “Otherness”
Military Sexual Trauma
Military Transgender Issues and Policy
Navy Psychology Practice on Aircraft Carriers
Ethical and Effective Practice of Supervision
Supervision Training: Defining and Assessing Competencies
Special Operations in Navy Psychology
Psychopharmacology
Substance Use Disorder Assessment

Collaborative Assessment and Management of Suicidality
MMPI2-RF
Personality Assessment Inventory
Rorschach Performance Assessment System

ADJUNCT FACULTY

Adjunct training faculty members are considered critical in the delivery of the internship program as presently outlined.

Adjunct Psychology Faculty: Licensed psychologists not part of the Core Faculty but readily available to interns for adjunctive supervision and consultation.
Psychiatry Staff: Attending Psychiatrists on Inpatient Service, Attending Psychiatrists on Psychiatric Consultation Liaison Service, Attending Psychiatrists on Adult Outpatient Service
Outside Consultants: Provide didactic material in areas supplementing Navy CPIP faculty expertise.

QUALITY ASSURANCE

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

I. Supervisors will submit written rotation competency evaluations to the intern and the Program Director indicating that the evaluation of the intern has taken place as scheduled (mid-point and end of rotation).

II. At the mid-point and end of the internship year, each intern will submit to the Program Director a formal evaluation of the training received.

III. At the end of each 8 week or 16 week rotation, each intern will submit to the Program Director a formal evaluation of the rotation-specific training, and of the supervision received.

APPENDIX A

INTERN RECRUITMENT AND SELECTION

Application to the Navy Clinical Psychology Internship Program at Walter Reed National Military Medical Center is processed through the Navy Recruiting Command (for Navy Officer commissioning clearance) and through the APPIC Match. The officer commissioning part of the application process is NOT made directly to the internship program. As applicants to the internship are also applying to become active duty naval officers if matched to our program through the APPIC match, they must meet all age, security background check, and medical requirements for commissioning as naval officers prior to being placed on the internship's APPIC match list. Applicants do not need to be in the military to apply, and despite the extensive officer commissioning background process during the application, there is no subsequent military service obligation unless an applicant matches with the internship through the APPIC match.

The Navy internship sites at Walter Reed National Military Medical Center and Naval Medical Center San Diego are not a consortium. They are separately accredited by the American Psychological Association (APA) and are listed separately on the APPIC website. Applicants may apply to one or both of the internships. In order to be placed on the APPIC match list for the Navy internships at Walter Reed National Military Medical Center Bethesda and Naval Medical Center San Diego, applicants must apply to each internship program separately.

Application packages will include the standard APPIC application (including graduate training director verification of readiness for internship), transcripts of all graduate school education, a curriculum vitae, and letters of reference from graduate school professors and practicum supervisors. Letters from professors and supervisors directly familiar with applicants' clinical work are most helpful in the application review process. Additionally, Navy Recruiting will include required naval officer recruiting paperwork, the physical examination, and the criminal background check in the application package.

Our internship and the Navy welcome and encourage applications from men and women of diverse backgrounds. We select psychology interns on a competitive basis without regard to race, color, religion, creed, sex or national origin (Article 1164, Navy Regulations). In accordance with United States law regarding military officers, applicants must be United States citizens and cannot hold dual citizenship. (Applicants who hold dual citizenship must be willing to relinquish non-U.S. citizenship prior to commissioning as a military officer). As noted above, applicants must meet age, security background check, and medical qualification requirements for Navy officer commissioning prior to being placed on the internship's APPIC Match ranking list.

It is important to note that the Navy accepts internship applications only from APA-accredited doctoral programs in clinical or counseling psychology.

All doctoral degree requirements other than the internship and doctoral dissertation must be completed prior to the start of the internship year. This includes all required coursework and pre-internship practicum experiences. In addition, all written and/or oral comprehensive examinations and approval of the dissertation proposal by the applicant's full dissertation

committee must be completed prior to the APPIC Match list submission deadline. Whenever possible, the dissertation should be completed prior to internship, but this is not a requirement.

The Navy internships have not established a required number of practicum hours, or required types of practicum settings, to be considered for our internships. However, given the predominantly adult focus of the program and of Navy Psychology in general, we specifically seek applicants with practicum experience in generalist psychological assessment and psychotherapy with adults. Experience treating moderate to severe psychopathology in adults is preferred but not mandatory. Applicants with minimal experience with adults, or with adult experience in narrowly focused specialty areas such as neuropsychological assessment, would be at a significant disadvantage in our review and APPIC ranking of applicants. Applicants with minimal experience with psychological assessment of adults would also be at a disadvantage.

Graduate students interested in applying to the Navy Clinical Psychology Internship Programs at Walter Reed National Military Medical Center Bethesda and/or Naval Medical Center San Diego are advised to contact the Navy Recruiting Office in their local areas. This office can typically be found online and in the Government Pages of the local telephone directory. Applicants should specifically ask for a Medical Programs Officer Recruiter. Often, small recruiting offices will not have Medical Programs Officer Recruiters, but can easily direct the applicant to the closest one.

Applicants are strongly encouraged to visit the internship sites in which they are interested, and to which they have been invited for interviews during the APPIC application process. An in-person interview at one of the Navy sites is required. An interview at both sites is preferred. However, we understand the investment of time and finances for the APPIC Match process, and are happy to conduct phone interviews when travel to both Navy internship sites is prohibitive for the applicant. Additionally, applicants are strongly encouraged to contact the Program Director with any questions or concerns.

APPENDIX B: SAMPLE COMPETENCY EVALUATIONS
Walter Reed National Military Medical Center
Clinical Psychology Internship Program

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

OUTPATIENT ROTATION

Trainee Name: Click here to enter text.

Supervisor Name: Click here to enter text.

Rotation: Choose an item. Choose an item.

Evaluation Period: Start Date: Click here to enter a date. **End Date:** Click here to enter a date.

ASSESSMENT METHOD(S) FOR COMPETENCIES

☐Direct Observation
☐Videotape
☐Audiotape
☐Case Presentation
☐Other: Click here to enter text.
☐Review of Written Work
☐Review of Raw Test Data
☐Discussion of Clinical Interaction
☐Comments from Other Staff

COMPETENCY RATINGS DESCRIPTIONS

A **Advanced/Skills comparable to autonomous practice at the licensure level.**

Rating expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however supervision is required while in training status.

P **Proficient/Occasional supervision needed.**

A frequent rating at completion of internship. Competency attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision**

Minimum rating for passing a rotation. Common rating throughout internship. Routine supervision of activities required.

E **Entry level/Continued intensive supervision is needed**

Required intensive supervision efforts are documented on the Individual Development Plan.

R **Needs remedial work**

Requires remedial work.

PROFESSIONAL INTERPERSONAL BEHAVIOR (PWC – Professional Values, Attitudes, and Behavior)

Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.

N/O	☐	Not Observed.
A	☐	Smooth working relationships, handles differences openly, tactfully and effectively.
P	☐	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.
I	☐	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with rare interpersonal concerns with colleagues.
E	☐	Ability to participate in team model is limited, relates well to peers and supervisors. Requires intensive supervision (for a trainee at this level) to identify and or address interpersonal concerns with colleagues.
R	☐	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

SEEKS CONSULTATION/SUPERVISION (PWC – Communication and Interpersonal Skills)

Seeks consultation or supervision as needed and uses it productively.

N/O	☐	Not Observed.
A	☐	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms. Maintains excellent insight into personal strengths and limitations. Actively seeks assistance to improve areas of weakness and is effective in doing so.
P	☐	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, rarely over or under-estimates need for supervision. Maintains appropriate insight into personal strengths and limitations. Almost always seeks assistance to improve areas of weakness and is almost always effective in doing so.
I	☐	Generally accepts supervision well. Needs supervisory input for determination of readiness to try new skills. Generally aware of strengths and limitations and open to accepting feedback in these areas. Demonstrates ongoing efforts to improve areas of weakness.
E	☐	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
R	☐	Frequently defensive and inflexible, resists important and necessary feedback and/or lacks insight into personal limitations.

EFFECTIVE COMMUNICATION (PWC – Communication and Interpersonal Skills)

Responsible for key patient communication tasks (e.g. phone calls, written correspondence, case management), and completes tasks promptly. Keeps supervisors aware of whereabouts as needed. Routinely communicates with faculty and supervisors when absences occur. Proactive and clear in communication style.

N/O	☐	Not Observed.
A	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. Routinely communicates proactively and effectively.
P	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. May occasionally require prompting to clarify issues, but quickly clarifies and effectively applies lessons learned in future settings.
I	☐	Mostly maintains clear communication with faculty and primary supervisors. Routinely requires prompting to clarify issues. Struggles to anticipate when/where proactive communication would assist in clinical duties.
E	☐	Needs considerable direction from supervisor. Routinely struggles to communicate effectively without prompting from supervisor.
R	☐	May seem unconcerned about proactive communication and coordination. Neglects to keep faculty and chain of command informed. Unresponsive to feedback.

TIME MANAGEMENT, ADMINISTRATIVE COMPETENCE, AND DOCUMENTATION (PWC – Professional Values, Attitudes, and Behaviors)

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects. All patient contacts are well documented. Records include crucial information.

N/O	☐	Not Observed.
A	☐	Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
P	☐	Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
I	☐	Uses supervisory feedback well to improve documentation. May require some feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
E	☐	Needs considerable direction from supervisor. May leave out crucial information.
R	☐	May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

KNOWLEDGE OF ETHICS AND LAW (PWC – Ethical and Legal Standards)

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

N/O	☐	Not Observed.

A	☐	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed.
P	☐	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
I	☐	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
E	☐	Often unaware of important ethical and legal issues.
R	☐	Disregards important supervisory input regarding ethics or law.

PATIENT RAPPORT (PWC – Intervention)

Consistently achieves a good rapport with patients.

N/O	☐	Not Observed.
A	☐	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.
P	☐	Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.
I	☐	Actively developing skills with new populations and able to develop rapport with minimal supervision efforts. Relates well when has prior experience with the population.
E	☐	Has difficulty establishing rapport.
R	☐	Alienates patients or shows little ability to recognize problems.

SENSITIVITY TO PATIENT DIVERSITY (PWC – Individual and Cultural Diversity)

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

N/O	☐	Not Observed.
A	☐	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
P	☐	Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
I	☐	Resolves lack of knowledge with some patient groups effectively through supervision. Open to feedback regarding limits of competence.
E	☐	Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.
R	☐	Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND (PWC – Individual and Cultural Diversity)

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

N/O	☐	Not Observed.
A	☐	Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.
P	☐	Aware of own cultural background. Readily acknowledges own culturally-based assumptions.
I	☐	Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.
E	☐	Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.
R	☐	Has little insight into own cultural beliefs even after supervision.

DIAGNOSTIC SKILL (PWC - Assessment)

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM. Utilizes historical, interview and psychometric data to diagnose accurately.

N/O	☐	Not Observed.
A	☐	Demonstrates a thorough knowledge of psychiatric classification, including relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.
P	☐	Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good.
I	☐	Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May occasionally miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.
E/R	☐	Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM-V criteria to develop a diagnostic conceptualization.

REPORT WRITING SKILLS (PWC – Assessment; Communication)

Writes a well-organized intake report. Addresses relevant history, diagnosis, mental status, treatment plan and recommendations in a clear and concise fashion.

N/O	☐	Not Observed.
A	☐	Report is clear and thorough, follows a coherent outline, is an effective summary of major relevant issues. Thorough history supports clear diagnostic conclusions. Recommended treatment plan is consistent with history and diagnosis.
P	☐	Report covers essential points without error. Readily completes intake reports and makes useful and relevant recommendations.

I	☐	Uses supervision effectively for assistance in determining important points to highlight. Report may need polish in cohesiveness and organization.
E/R	☐	Inaccurate conclusions or grammar interfere with communication. Or reports are poorly organized and require major rewrites.

GENERAL INTERVIEWING SKILLS (PWC – Assessment; Intervention)

Can gather necessary history and diagnostic information; displays an organized approach; interview sets the patient at ease and helps to build rapport.

N/O	☐	Not Observed.
A	☐	Gathers all necessary history and diagnostic information in most cases. Always does so in an organized, attentive, thoughtful way, even in the most complex cases. Quickly establishes patient rapport, and uses style tailored to the individual patient.
P	☐	Gathers necessary history and diagnostic information in an organized manner, in most cases. Ensures that thoughtful inquiry is balanced with timely and organized completion of the interview.
I	☐	Shows improvement with practice and supervision, and evidences adequate reflective and empathic skills most of the time.
E	☐	Demonstrates the basics of interviewing technique but frequently misses critical Historical data. May require significant supervision to arrive at diagnostic conclusions. Difficulty developing treatment plans supported by history and diagnosis.
R	☐	Is disorganized and superficial in interview, even in the most basic cases, and despite repeated feedback and assistance from supervisor. Routinely misses important history. Does not engage the patient effectively; cannot establish basic rapport. Struggles to adequately empathize with the patient.

PATIENT RISK MANAGEMENT AND CONFIDENTIALITY (PWC - Assessment)

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

N/O	☐	Not Observed.
A	☐	Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consults (as needed). Establishes appropriate short-term crisis plans with patients. Solid working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide.
P	☐	Recognizes and effectively manages safety issues. Appropriately documents risk. Initiates appropriate actions to manage patient risk. Promptly discusses confidentiality issues. Working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide. Seeks supervision, as needed, with complex cases.

I	☐	Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. May occasionally need input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient. Needs prompting to utilize DoD/VA Clinical Practice Guidelines.
E	☐	Delays or forgets to ask about important safety issues. Does not document risk appropriately. But does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.
R	☐	Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor. Cannot apply DoD/VA Clinical Practice Guidelines in risk assessment.

CASE CONCEPTUALIZATION AND TREATMENT GOALS (PWC – Intervention)

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

N/O	☐	Not Observed.
A	☐	Independently produces good case conceptualizations within own preferred theoretical orientation; can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.
P	☐	Independently reaches a good case conceptualization within own preferred theoretical orientation. Readily identifies emotional issues. Sets appropriate goals and distinguishes realistic and unrealistic goals.
I	☐	Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.
E/R	☐	Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues. Unable to set appropriate treatment goals with patient.

THERAPEUTIC INTERVENTIONS (PWC – Intervention)

Interventions are well-timed, effective and consistent with empirically supported treatments.

N/O	☐	Not Observed.
A	☐	Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.
P	☐	Most interventions and interpretations facilitate patient acceptance and change. Solidly developing timing and delivery of more difficult interventions.
I	☐	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.

E/R	☐	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

EMPIRICALLY SUPPORTED INTERVENTIONS FOR PTSD (PWC – Intervention)

Interventions for Post-Traumatic Stress Disorder are well timed, patient centered, effective and consistent with empirically supported treatments (e.g., Prolonged Exposure Therapy or Cognitive Processing Therapy).

N/O	☐	Not Observed.
A	☐	Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed. Able to independently identify knowledge and practice gaps and spontaneously seek out additional assistance or supervision when needed.
P	☐	Most interventions and interpretations facilitate patient acceptance and change. Solidly developing timing and delivery of more difficult interventions. Seeks ongoing supervision to advance skills.
I	☐	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.
E/R	☐	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting empirically supported interventions to patients' level of understanding and motivation. Struggles with asking for assistance or additional supervision. Requires close observation and supervision when using empirically supported treatments.

EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE) (PWC – Intervention)

Understands and uses own emotional reactions to the patient productively in the treatment.

N/O	☐	Not Observed.
A	☐	During session, uses countertransference to formulate hypotheses about patient's current And historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.
P	☐	Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions generally presented in the following session.
I	☐	Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is sometimes needed to process the information gained.
E	☐	When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.
R	☐	Unable to see or denies countertransference issues, even with supervisory input.

GROUP THERAPY SKILLS AND PREPARATION (PWC – Intervention)

Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psycho-educational, readies materials for group, and understands each session's goals and tasks.

N/O	☐	Not Observed.
A	☐	Elicits participation and cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of co-therapist.
P	☐	Elicits participation and cooperation from all members. Independently prepares for each session without prompting. Able to independently conduct routine groups for common psychiatric conditions. Able to appropriately confront problems, seeking additional supervision as needed. Effectively collaborates with a co-therapist.
I	☐	Welcomes ongoing supervision to identify key issues and initiate group interaction. Actively working on identifying own strengths and weaknesses as a group leader. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.
E	☐	Has significant inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.
R	☐	Defensive or lacks insight when discussing strengths and weaknesses. Frequently unprepared for content or with materials.

COUPLES THERAPY SKILLS AND PREPARATION (PWC – Intervention)

Intervenes with couples skillfully, able to elicit relationship difficulties to be addressed, able to manage the "give and take" between all parties, can formulate mutual initial and ongoing therapy goals, able to provide couple with foundational relationship information including the ability to normalize common sticking points, able to teach effective communication patterns of interaction and can model and coach these skills.

N/O	☐	Not Observed.
A	☐	Elicits participation and cooperation from the couple, confronts problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage the session alone in absence of co-therapist.
P	☐	Elicits participation and cooperation from the couple. Independently prepares for each session without prompting. Able to appropriately confront problems, seeking additional supervision as needed. Effectively collaborates with a co-therapist.
I	☐	Welcomes ongoing supervision to identify key issues and initiate couple interaction. Actively working on identifying own strengths and weaknesses as a therapist. Identifies problematic issues in process but requires assistance to handle them. May require assistance organizing informational materials.
E	☐	Has significant inadequacies in understanding and implementation of couples therapy. Unable to maintain control in session to cover content areas. Preparation is sometimes disorganized.

R	☐	Defensive or lacks insight when discussing strengths and weaknesses. Frequently unprepared for content or with materials.

SEEKS CURRENT SCIENTIFIC KNOWLEDGE (PWC – Research)

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

N/O	☐	Not Observed.
A/P	☐	Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.
I	☐	Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.
E	☐	Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.
R	☐	Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

CONSULTATION GUIDANCE (PWC – Consultation)

Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question. Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/O	☐	Not Observed.
A/P	☐	Relates well to those seeking input, is able to provide appropriate feedback.
I	☐	Requires occasional input regarding the manner of delivery or type of feedback given, with additional guidance required on more complex cases.
E	☐	Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R	☐	Unable to establish rapport.

MILITARY BEARING (Program- Specific Competency)

Demonstrates proper military etiquette and follows protocol, consistently and effectively comports self as a professional military officer with a presence that instills confidence and solid interpersonal skills, demonstrates proper uniform wear, utilizes proper social skills in a formal military setting.

N/O	☐	Not Observed.
A	☐	Viewed by officers as the standard to which others should meet. Exudes a confident presence without being arrogant or aggressive. Places mission needs above own.
P	☐	Consistently follows military protocols and demonstrates appropriate officer comportment without prompting. Wears the uniform correctly. Able to adapt interpersonal style to formal and informal demands of different military settings. Respectful of all ranks and civilians.
I	☐	Generally follows military protocols and demonstrates appropriate comportment, with occasional on the spot correction and prompts by supervisors. Wear of the uniform is sufficient. Usually is able to distinguish between and adapt to formal vs. informal military setting demands. Officer is respectful of senior officers/civilians and progressing in learning how to supervise/be a role model to junior Service members.
E	☐	Inadequate comportment as a military officer usually demonstrated or egregious breeches in protocol/etiquette observed. Does not consistently wear the uniform properly. Does not consistently adapt interpersonal interactions to formal vs. informal military setting demands. Instances of disrespect have been reported.
R	☐	Does not observe military customs and courtesies, follow protocols, properly wear the uniform, or violates other aspects of appropriate officership. Instances of disrespect have been reported.

MILITARY FUND OF KNOWLEDGE AND APPLICATION TO PRACTICE (Program-Specific Competency)

Demonstrates appropriate breadth and depth of applicable military knowledge and is able to apply information to clinical practice. Functional military knowledge effectively informs clinical decision making, treatment plans, recommendations, referrals, consultation methods, etc.

N/O	☐	Not Observed.
A	☐	Demonstrates expansive functional knowledge of the military, expertly applies knowledge to clinical practice, and is called upon as a consultant on a variety of different topics and in multiple settings in military psychology.
P	☐	Able to consistently apply knowledge of the military and military culture to clinical practice without supervisor's assistance. Military knowledge is effectively combined with clinical practice to produce solid case conceptualization, treatment recommendations, clinical decision making, referrals, and consultation practices.
I	☐	Possesses basic understanding/knowledge of the military and military culture but requires routine supervision to supplement and expand fund of knowledge. Requires supervisor's assistance to apply military specific information to clinical practice.
E	☐	Insufficient knowledge of the military and does not consistently apply information to clinical practice.
R	☐	Unaware of or disregards military culture or protocol. Does not apply military knowledge to clinical practice.

MILITARY SPECIFIC MENTAL HEALTH EVALUATIONS (Program-Specific Competency)

Demonstrates ability to appropriately evaluate and identify major issues relating to military specific evaluations, prepare appropriate paperwork, effectively communicate the purpose of the evaluation to the Service Member and results to the command.

N/O	☐	Not Observed.
A	☐	Well versed in applicable regulations and able to apply guidelines to make well informed clinical decisions and recommendations, even with the most complex cases. Effectively provides consultation and references appropriately regulations without assistance. Prepares reports on time. Effectively interfaces with commanders. Gathers necessary collateral data and information from AHLTA prior to evaluation.
P	☐	Able to conduct routine evaluations without the assistance of a supervisor. Able to identify associated regulations. May require some consultation/assistance with especially complex cases. Reports are complete and accurate. Effective consultation provided to commanders.
I	☐	Requires ongoing supervision to conduct routine and complex evaluations to identify associated regulations. Occasionally needs assistance identifying sources of collateral data and collecting collateral information. Reports are timely but may require some assistance from the supervisor to improve organization or recommendations. May need occasional assistance with developing recommendations to command.
E/R	☐	Cannot identify or does not apply associated regulations, collect collateral data, or formulate sufficient recommendations. Does not adequately prepare for evaluations. Reports require significant editing by supervisors and may occasionally be late.

EVALUATION TOTALS

Command Directed Mental Health Evaluations	Select a number.
Administrative Separations	Select a number.
Fitness for Duty	Select a number.
Special Activity Duty Evaluations	Select a number.
Personnel Security Program Evaluations	Select a number.
TDRL Evaluations	Select a number.

SUPERVISOR COMMENTS

SUMMARY OF STRENGTHS:

Click here to enter text.

AREAS OF CONTINUED DEVELOPMENT, INCLUDING RECOMMENDATIONS:

Click here to enter text.

AREAS OF REMEDIATION, INCLUDING RECOMMENDATIONS:

Click here to enter text.

Trainee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Training Director Signature: _____ Date: _____

Walter Reed National Military Medical Center
Clinical Psychology Internship Program

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

PROFESSION-WIDE COMPETENCIES

Trainee Name: Click here to enter text.

Supervisor Name: Click here to enter text.

Rotation: Choose an item. Choose an item.

Evaluation Period: Start Date: Click here to enter a date. **End Date:** Click here to enter a date.

ASSESSMENT METHOD(S) FOR COMPETENCIES

☐Direct Observation
☐Videotape
☐Audiotape
☐Case Presentation
☐Other: Click here to enter text.
☐Review of Written Work
☐Review of Raw Test Data
☐Discussion of Clinical Interaction
☐Comments from Other Staff

COMPETENCY RATINGS DESCRIPTIONS

A **Advanced/Skills comparable to autonomous practice at the licensure level.**

Rating expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however supervision is required while in training status.

P **Proficient/Occasional supervision needed.**

A frequent rating at completion of internship. Competency attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision**

Minimum rating for passing a rotation. Common rating throughout internship. Routine supervision of activities required.

E **Entry level/Continued intensive supervision is needed**

Required intensive supervision efforts are documented on the Individual Development Plan.

R **Needs remedial work**

Requires remedial work.

PROFESSIONAL INTERPERSONAL BEHAVIOR (PWC – Professional Values, Attitudes, and Behaviors)

Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.

N/O	☐	Not Observed.
A	☐	Smooth working relationships, handles differences openly, tactfully and effectively.
P	☐	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.
I	☐	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with rare interpersonal concerns with colleagues.
E	☐	Ability to participate in team model is limited, relates well to peers and supervisors. Requires intensive supervision (for a trainee at this level) to identify and or address interpersonal concerns with colleagues.
R	☐	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

SEEKS CONSULTATION/SUPERVISION (PWC – Communication and Interpersonal Skills)

Seeks consultation or supervision as needed and uses it productively.

N/O	☐	Not Observed.
A	☐	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms. Maintains excellent insight into personal strengths and limitations. Actively seeks assistance to improve areas of weakness and is effective in doing so.
P	☐	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, rarely over or under-estimates need for supervision. Maintains appropriate insight into personal strengths and limitations. Almost always seeks assistance to improve areas of weakness and is almost always effective in doing so.
I	☐	Generally accepts supervision well. Needs supervisory input for determination of readiness to try new skills. Generally aware of strengths and limitations and open to accepting feedback in these areas. Demonstrates ongoing efforts to improve areas of weakness.
E	☐	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
R	☐	Frequently defensive and inflexible, resists important and necessary feedback and/or lacks insight into personal limitations.

USES POSITIVE COPING STRATEGIES (PWC – Professional Values, Attitudes, and Behaviors)

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

N/O	☐	Not Observed.

A	☐	Good awareness of personal and professional problems. Stressors have minimal impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues. Routinely engages/employs effective positive coping strategies.
P	☐	Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact. Routinely engages employs effective positive coping strategies.
I	☐	Occasionally uses supervision time to minimize the effect of stressors on professional functioning. Able to successfully employ positive coping strategies to minimize effect of stressors on professional practice, with occasional prompting from supervisor. Accepts reassurance from supervisor well.
E	☐	Personal problems can significantly disrupt professional functioning.
R	☐	Denies problems or otherwise does not allow them to be addressed effectively.

PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION (PWC – Professional Values, Attitudes, and Behaviors)

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

N/O	☐	Not Observed.
A	☐	Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
P	☐	Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
I	☐	Uses supervisory feedback well to improve documentation. May require some feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
E	☐	Needs considerable direction from supervisor. May leave out crucial information.
R	☐	May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

EFFICIENCY AND TIME MANAGEMENT (PWC – Professional Values, Attitudes, and Behaviors)

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

N/O	☐	Not Observed.
A	☐	Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

P	☐	Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner.
I	☐	Completes work effectively and promptly by using supervision time for guidance. Rarely needs reminders to meet deadlines.
E	☐	Dependent on reminders or additional deadlines to complete tasks.
R	☐	Frequently has difficulty with timeliness or tardiness or unaccounted absences are a problem.

KNOWLEDGE OF ETHICS AND LAW (PWC – Ethical and Legal Standards)

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

N/O	☐	Not Observed.
A	☐	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed
P	☐	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
I	☐	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
E	☐	Often unaware of important ethical and legal issues.
R	☐	Disregards important supervisory input regarding ethics or law.

EFFECTIVE COMMUNICATION (PWC – Communication and Interpersonal Skills)

Responsible for key patient communication tasks (e.g. phone calls, written correspondence, case management), and completes tasks promptly. Keeps supervisors aware of whereabouts as needed. Routinely communicates with faculty and supervisors when absences occur. Proactive and clear in communication style.

N/O	☐	Not Observed.
A	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. Routinely communicates proactively and effectively.
P	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. May occasionally require prompting to clarify issues, but quickly clarifies and effectively applies lessons learned in future settings.
I	☐	Mostly maintains clear communication with faculty and primary supervisors. Routinely requires prompting to clarify issues. Struggles to anticipate when/where proactive communication would assist in clinical duties.

E	☐	Needs considerable direction from supervisor. Routinely struggles to communicate effectively without prompting from supervisor.
R	☐	May seem unconcerned about proactive communication and coordination. Neglects to keep faculty and chain of command informed. Unresponsive to feedback.

PATIENT RAPPORT (PWC – Intervention)

Consistently achieves a good rapport with patients.

N/O	☐	Not Observed.
A	☐	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.
P	☐	Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.
I	☐	Actively developing skills with new populations and able to develop rapport with minimal supervision efforts. Relates well when has prior experience with the population.
E	☐	Has difficulty establishing rapport.
R	☐	Alienates patients or shows little ability to recognize problems.

SENSITIVITY TO PATIENT DIVERSITY (PWC – Individual and Cultural Diversity)

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

N/O	☐	Not Observed.
A	☐	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
P	☐	Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
I	☐	Resolves lack of knowledge with some patient groups effectively through supervision. Open to feedback regarding limits of competence.
E	☐	Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.
R	☐	Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND (PWC – Individual and Cultural Diversity)

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

N/O	☐	Not Observed.
A	☐	Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.
P	☐	Aware of own cultural background. Readily acknowledges own culturally-based assumptions.
I	☐	Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.
E	☐	Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.
R	☐	Has little insight into own cultural beliefs even after supervision.

DIAGNOSTIC SKILL (PWC – Assessment; Intervention)

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclatur and DSM. Utilizes historical, interview and psychometric data to diagnose accurately.

N/O	☐	Not Observed.
A	☐	Demonstrates a thorough knowledge of psychiatric classification, including relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.
P	☐	Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good.
I	☐	Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May occasionally miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.
E/R	☐	Has significant deficits in understanding of the psychiatric classification system and/or ability to Nuse DSM-V criteria to develop a diagnostic conceptualization.

GENERAL INTERVIEWING SKILLS (PWC – Assessment; Intervention)

Can gather necessary history and diagnostic information; displays an organized approach; interview sets the patient at ease and helps to build rapport.

N/O	☐	Not Observed.

A	☐	Gathers all necessary history and diagnostic information in most cases. Always does so in an organized, attentive, thoughtful way, even in the most complex cases. Quickly establishes patient rapport, and uses style tailored to the individual patient.
P	☐	Gathers necessary history and diagnostic information in an organized manner, in most cases. Ensures that thoughtful inquiry is balanced with timely and organized completion of the interview.
I	☐	Shows improvement with practice and supervision, and evidences adequate reflective and empathic skills most of the time.
E	☐	Demonstrates the basics of interviewing technique but frequently misses critical historical data. May require significant supervision to arrive at diagnostic conclusions. Difficulty developing treatment plans supported by history and diagnosis.
R	☐	Is disorganized and superficial in interview, even in the most basic cases, and despite repeated feedback and assistance from supervisor. Routinely misses important history. Does not engage the patient effectively; cannot establish basic rapport. Struggles to adequately empathize with the patient.

PATIENT RISK MANAGEMENT AND CONFIDENTIALITY (PWC – Assessment; Intervention)

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

N/O	☐	Not Observed.
A	☐	Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consults (as needed). Establishes appropriate short-term crisis plans with patients. Solid working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide.
P	☐	Recognizes and effectively manages safety issues. Appropriately documents risk. Initiates appropriate actions to manage patient risk. Promptly discusses confidentiality issues. Working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide. Seeks supervision, as needed, with complex cases.
I	☐	Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. May occasionally need input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient. Needs prompting to utilize DoD/VA Clinical Practice Guidelines.
E	☐	Delays or forgets to ask about important safety issues. Does not document risk appropriately. But does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.
R	☐	Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor. Cannot apply DoD/VA Clinical Practice Guidelines in risk assessment.

CASE CONCEPTUALIZATION AND TREATMENT GOALS (PWC – Intervention)

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

N/O	☐	Not Observed.
A	☐	Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.
P	☐	Independently reaches a good case conceptualization within own preferred theoretical orientation. Readily identifies emotional issues. Sets appropriate goals and distinguishes realistic and unrealistic goals.
I	☐	Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.
E/R	☐	Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives impo1tant emotional issues. Unable to set appropriate treatment goals with patient.

THERAPEUTIC INTERVENTIONS (PWC – Intervention)

Interventions are well-timed, effective and consistent with empirically supported treatments.

N/O	☐	Not Observed.
A	☐	Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.
P	☐	Most interventions and interpretations facilitate patient acceptance and change. Solidly developing timing and delivery of more difficult interventions.
I	☐	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.
E/R	☐	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

EMPIRICALLY SUPPORTED INTERVENTIONS FOR PTSD (PWC – Intervention)

Interventions for Post-Traumatic Stress Disorder are well timed, patient centered, effective and consistent with empirically supported treatments (e.g., Prolonged Exposure Therapy or Cognitive Processing Therapy).

N/O	☐	Not Observed.
A	☐	Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed. Able to independently identify knowledge and practice gaps and spontaneously seek out additional assistance or supervision when needed.

P	☐	Most interventions and interpretations facilitate patient acceptance and change. Solidly developing timing and delivery of more difficult interventions. Seeks ongoing supervision to advance skills.
I	☐	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.
E/R	☐	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting empirically supported interventions to patients' level of understanding and motivation. Struggles with asking for assistance or additional supervision. Requires close observation and supervision when using empirically supported treatments.

EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE) (PWC – Intervention)

Understands and uses own emotional reactions to the patient productively in the treatment.

N/O	☐	Not Observed.
A	☐	During session, uses countertransference to formulate hypotheses about patient's current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.
P	☐	Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions generally presented in the following session.
I	☐	Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is sometimes needed to process the information gained.
E	☐	When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.
R	☐	Unable to see or denies countertransference issues, even with supervisory input.

SEEKS CURRENT SCIENTIFIC KNOWLEDGE (PWC – Research)

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

N/O	☐	Not Observed.
A/P	☐	Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.
I	☐	Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.

E	☐	Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.
R	☐	Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

CONSULTATIVE GUIDANCE (PWC – Consultation)

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/O	☐	Not Observed.
A/P	☐	Relates well to those seeking input, is able to provide appropriate feedback.
I	☐	Requires occasional input regarding the manner of delivery or type of feedback given, with additional guidance required on more complex cases.
E	☐	Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R	☐	Unable to establish rapport.

MILITARY BEARING (Program-Specific Competency)

Demonstrates proper military etiquette and follows protocol, consistently and effectively comports self as a professional military officer with a presence that instills confidence and solid interpersonal skills, demonstrates proper uniform wear, utilizes proper social skills in a formal military setting.

N/O	☐	Not Observed.
A	☐	Viewed by officers as the standard to which others should meet. Exudes a confident presence without being arrogant or aggressive. Places mission needs above own.
P	☐	Consistently follows military protocols and demonstrates appropriate officer comportment without prompting. Wears the uniform correctly. Able to adapt interpersonal style to formal and informal demands of different military settings. Respectful of all ranks and civilians.
I	☐	Generally follows military protocols and demonstrates appropriate comportment, with occasional on the spot correction and prompts by supervisors. Wear of the uniform is sufficient. Usually is able to distinguish between and adapt to formal vs. informal military setting demands. Officer is respectful of senior officers/civilians and progressing in learning how to supervise/be a role model to junior Service members.
E	☐	Inadequate comportment as a military officer usually demonstrated or egregious breeches in protocol/etiquette observed. Does not consistently wear the uniform properly. Does not consistently adapt interpersonal interactions to formal vs. informal military setting demands. Instances of disrespect have been reported.

R	☐	Does not observe military customs and courtesies, follow protocols, properly wear the uniform, or violates other aspects of appropriate officership. Instances of disrespect have been reported.

MILITARY FUND OF KNOWLEDGE AND APPLICATION TO PRACTICE (Program-Specific Competency)

Demonstrates appropriate breadth and depth of applicable military knowledge and is able to apply information to clinical practice. Functional military knowledge effectively informs clinical decision making, treatment plans, recommendations, referrals, consultation methods, etc.

N/O	☐	Not Observed.
A	☐	Demonstrates expansive functional knowledge of the military , expertly applies knowledge to clinical practice, and is called upon as a consultant on a variety of different topics and in multiple settings in military psychology.
P	☐	Able to consistently apply knowledge of the military and military culture to clinical practice without supervisor's assistance. Military knowledge is effectively combined with clinical practice to produce solid case conceptualization, treatment recommendations, clinical decision making, referrals, and consultation practices.
I	☐	Possesses basic understanding/knowledge of the military and military culture but requires routine supervision to supplement and expand fund of knowledge. Requires supervisor's assistance to apply military specific information to clinical practice.
E	☐	Insufficient knowledge of the military and does not consistently apply information to clinical practice.
R	☐	Unaware of or disregards military culture or protocol. Does not apply military knowledge to clinical practice.

SUPERVISOR COMMENTS

PERFORMANCE SUMMARY:

Click here to enter text.

AREAS OF CONTINUED PROFESSIONAL DEVELOPMENT, INCLUDING RECOMMENDATIONS:

Click here to enter text.

Trainee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Training Director Signature: _____ Date: _____

Walter Reed National Military Medical Center
Clinical Psychology Internship Program

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

PSYCHOLOGICAL ASSESSMENT ROTATION

Trainee Name: Click here to enter text.

Supervisor Name: Click here to enter text.

Rotation: Choose an item. Choose an item.

Evaluation Period: Start Date: Click here to enter a date. **End Date:** Click here to enter a date.

ASSESSMENT METHOD(S) FOR COMPETENCIES

☐Direct Observation
☐Videotape
☐Audiotape
☐Case Presentation
☐Other: Click here to enter text.
☐Review of Written Work
☐Review of Raw Test Data
☐Discussion of Clinical Interaction
☐Comments from Other Staff

COMPETENCY RATINGS DESCRIPTIONS

A **Advanced/Skills comparable to autonomous practice at the licensure level.**

Rating expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however supervision is required while in training status.

P **Proficient/Occasional supervision needed.**

A frequent rating at completion of internship. Competency attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision**

Minimum rating for passing a rotation. Common rating throughout internship. Routine supervision of activities required.

E **Entry level/Continued intensive supervision is needed**

Required intensive supervision efforts are documented on the Individual Development Plan.

R **Needs remedial work**

Requires remedial work.

PROFESSIONAL INTERPERSONAL BEHAVIOR (PWC – Professional Values, Attitudes, and Behaviors)

Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.

N/O	☐	Not Observed.
A	☐	Smooth working relationships, handles differences openly, tactfully and effectively.
P	☐	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.
I	☐	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with rare interpersonal concerns with colleagues.
E	☐	Ability to participate in team model is limited, relates well to peers and supervisors. Requires intensive supervision (for a trainee at this level) to identify and or address interpersonal concerns with colleagues.
R	☐	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

OBJECTIVE: SEEKS CONSULTATION/SUPERVISION (PWC – Communication and Interpersonal Skills)

Seeks consultation or supervision as needed and uses it productively.

N/O	☐	Not Observed.
A	☐	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms. Maintains excellent insight into personal strengths and limitations. Actively seeks assistance to improve areas of weakness and is effective in doing so.
P	☐	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, rarely over or under-estimates need for supervision. Maintains appropriate insight into personal strengths and limitations. Almost always seeks assistance to improve areas of weakness and is almost always effective in doing so.
I	☐	Generally accepts supervision well. Needs supervisory input for determination of readiness to try new skills. Generally aware of strengths and limitations and open to accepting feedback in these areas. Demonstrates ongoing efforts to improve areas of weakness.
E	☐	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
R	☐	Frequently defensive and inflexible, resists important and necessary feedback and/or lacks insight into personal limitations.

USES POSITIVE COPING STRATEGIES (PWC – Professional Values, Attitudes, and Behaviors)

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

N/O	☐	Not Observed.

A	☐	Good awareness of personal and professional problems. Stressors have minimal impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues. Routinely engages/employs effective positive coping strategies.
P	☐	Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact. Routinely engages employs effective positive coping strategies.
I	☐	Occasionally uses supervision time to minimize the effect of stressors on professional functioning. Able to successfully employ positive coping strategies to minimize effect of stressors on professional practice, with occasional prompting from supervisor. Accepts reassurance from supervisor well.
E	☐	Personal problems can significantly disrupt professional functioning.
R	☐	Denies problems or otherwise does not allow them to be addressed effectively.

PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION (PWC – Professional Values, Attitudes, and Behaviors)

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

N/O	☐	Not Observed.
A	☐	Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
P	☐	Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
I	☐	Uses supervisory feedback well to improve documentation. May require some feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
E	☐	Needs considerable direction from supervisor. May leave out crucial information.
R	☐	May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

EFFICIENCY AND TIME MANAGEMENT (PWC – Professional Values, Attitudes, and Behaviors)

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

N/O	☐	Not Observed.
A	☐	Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

P	☐	Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner.
I	☐	Completes work effectively and promptly by using supervision time for guidance. Rarely needs reminders to meet deadlines.
E	☐	Dependent on reminders or additional deadlines to complete tasks.
R	☐	Frequently has difficulty with timeliness or tardiness or unaccounted absences are a problem.

KNOWLEDGE OF ETHICS AND LAW (PWC – Ethical and Legal Standards)

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

N/O	☐	Not Observed.
A	☐	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed
P	☐	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
I	☐	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
E	☐	Often unaware of important ethical and legal issues.
R	☐	Disregards important supervisory input regarding ethics or law.

EFFECTIVE COMMUNICATION (PWC – Communication and Interpersonal Skills)

Responsible for key patient communication tasks (e.g. phone calls, written correspondence, case management), and completes tasks promptly. Keeps supervisors aware of whereabouts as needed. Routinely communicates with faculty and supervisors when absences occur. Proactive and clear in communication style.

N/O	☐	Not Observed.
A	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. Routinely communicates proactively and effectively.
P	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. May occasionally require prompting to clarify issues, but quickly clarifies and effectively applies lessons learned in future settings.
I	☐	Mostly maintains clear communication with faculty and primary supervisors. Routinely requires prompting to clarify issues. Struggles to anticipate when/where proactive communication would assist in clinical duties.
E	☐	Needs considerable direction from supervisor. Routinely struggles to communicate effectively without prompting from supervisor.
R	☐	May seem unconcerned about proactive communication and coordination. Neglects to keep faculty and chain of command informed. Unresponsive to feedback.

PATIENT RAPPORT (PWC – Assessment; Intervention)

Consistently achieves a good rapport with patients.

N/O	☐	Not Observed.
A	☐	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.
P	☐	Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.
I	☐	Actively developing skills with new populations and able to develop rapport with minimal supervision efforts. Relates well when has prior experience with the population.
E	☐	Has difficulty establishing rapport.
R	☐	Alienates patients or shows little ability to recognize problems.

SENSITIVITY TO PATIENT DIVERSITY (PWC – Individual and Cultural Diversity)

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

N/O	☐	Not Observed.
A	☐	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
P	☐	Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
I	☐	Resolves lack of knowledge with some patient groups effectively through supervision. Open to feedback regarding limits of competence.
E	☐	Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.
R	☐	Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND (PWC – Individual and Cultural Diversity)

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

N/O	☐	Not Observed.
A	☐	Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.
P	☐	Aware of own cultural background. Readily acknowledges own culturally-based assumptions.

I	☐	Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.
E	☐	Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.
R	☐	Has little insight into own cultural beliefs even after supervision.

DIAGNOSTIC SKILL (PWC – Assessment)

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclatur and DSM. Utilizes historical, interview and psychometric data to diagnose accurately.

N/O	☐	Not Observed.
A	☐	Demonstrates a thorough knowledge of psychiatric classification, including relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.
P	☐	Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good.
I	☐	Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May occasionally miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.
E/R	☐	Has significant deficits in understanding of the psychiatric classification system and/or ability to Nuse DSM-V criteria to develop a diagnostic conceptualization.

TOTAL NUMBER OF ASSESSMENTS COMPLETED THIS EVALUATION PERIOD Select a number.

PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION (PWC – Assessment)

Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered. Demonstrates competence in administering intelligence tests and personality inventories (e.g., MMPI-2, PAI).

N/O	☐	Not Observed.
A/P	☐	Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question.
I	☐	Occasional input needed regarding fine points of test administration. Occasionally needs reassurance that selected tests are appropriate.
E	☐	Needs continued supervision on frequently administered tests. Needs occasional consultation regarding appropriate tests to administer.
R	☐	Test administration is irregular, slow. Or often needs to recall patient to further testing sessions due to poor choice of tests administered.

PSYCHOLOGICAL TEST INTERPRETATION (PWC – Assessment)

Interprets the results of psychological tests used in his/her area of practice. Demonstrates competence interpreting intelligence tests and personality inventories.

N/O	☐	Not Observed.
A	☐	Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results.
P	☐	Demonstrates knowledge of scoring methods and reaches appropriate conclusions.
I	☐	Completes assessments on typical patients with some supervisory input, occasionally uncertain how to handle difficult patients or unusual findings. Understands basic use of tests, may occasionally reach inaccurate conclusions or over-rely on test manuals for interpretation.
E/R	☐	Significant deficits in understanding of psychological testing, over-reliance on test manuals for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.

Total Number of Tests Administered on Rotation:

MMPI-2	Select a number.
MCMI-III	Select a number.
PAI	Select a number.
RORSCHACH	Select a number.

Other: Click here to enter text.

ASSESSMENT WRITING SKILLS (PWC – Assessment; Communication and Interpersonal Skills)

Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.

N/O	☐	Not Observed.
A	☐	Report is clear and thorough, follows a coherent outline, is an effective summary of major relevant issues. Relevant test results are integrated into the report as primary evidence. Recommendations directly address referral questions.
P	☐	Report accurately covers essential points. Readily completes assessments and makes useful and relevant recommendations.
I	☐	Uses supervision effectively for assistance in determining important points to highlight. Report may need polish in cohesiveness and organization.
E/R	☐	Inaccurate conclusions or grammar interfere with communication. Or reports are poorly organized and require major rewrites.

FEEDBACK REGARDING ASSESSMENT (PWC – Assessment; Consultation)

Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver.

N/O	☐	Not Observed.
A	☐	Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to accommodate patient or caregiver needs.
P	☐	Develops and implements a plan for the feedback session. Identifies issues which may become problematic in the feedback session. Accommodates specific needs of patient or family.
I	☐	Develops plan for feedback session with the supervisor. Presents basic assessment results and supervisor addresses more complex issues. Continues to benefit from feedback on strengths and areas for improvement.
E	☐	Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver.
R	☐	Does not modify interpersonal style in response to feedback.

GENERAL INTERVIEWING SKILLS (PWC - Assessment)

Can gather necessary history and diagnostic information; displays an organized approach; interview sets the patient at ease and helps to build rapport.

N/O	☐	Not Observed.
A	☐	Gathers all necessary history and diagnostic information in most cases. Always does so in an organized, attentive, thoughtful way, even in the most complex cases. Quickly establishes patient rapport, and uses style tailored to the individual patient.
P	☐	Gathers necessary history and diagnostic information in an organized manner, in most cases. Ensures that thoughtful inquiry is balanced with timely and organized completion of the interview.
I	☐	Shows improvement with practice and supervision, and evidences adequate reflective and empathic skills most of the time.
E	☐	Demonstrates the basics of interviewing technique but frequently misses critical historical data. May require significant supervision to arrive at diagnostic conclusions. Difficulty developing treatment plans supported by history and diagnosis.
R	☐	Is disorganized and superficial in interview, even in the most basic cases, and despite repeated feedback and assistance from supervisor. Routinely misses important history. Does not engage the patient effectively; cannot establish basic rapport. Struggles to adequately empathize with the patient.

ASSESSING AND MANAGING SUICIDE RISK AND CONFIDENTIALITY ON THE PSYCHIATRIC CONSULTATION AND LIAISON SERVICE (PWC – Assessment; Intervention)

Effectively evaluates, manages and documents patient risk in an Emergency Department setting, and in other inpatient settings, to include suicidality, homicidality, and other safety issues.

N/O	☐	Not Observed.
A	☐	Independently able to develop an emergency plan that assures safety. Documentation is always complete and the rational for follow up care is clearly defined in treatment plan. Is fully aware of the processes and procedures needed to support this plan. Fully understands procedures related to hospital admission and is able to coordinate these services collaboratively with other providers.
P	☐	Able to integrate a risk assessment for suicidality early in a clinical interview and collects assessment information on an ongoing basis. Able to make a sound clinical judgment of the risk that a patient will attempt suicide in the short term. Is able to clearly document items related to suicidality and is able to develop a plan that addresses the client's acute suicide ideation and safety plan.
I	☐	Independently able to perform a thorough risk assessment and demonstrates a clear understanding of risk and protective factors. Is able to use this knowledge to illicit and document the warning signs of imminent risk of suicide. Is able to make sound clinical decisions about patient management and procedures for ongoing care. Has basic information about laws related to suicide and procedures for involuntary hospital admission. Is aware of the need to obtain records and information with collateral sources as appropriate.
E	☐	Demonstrates basic knowledge of risk suicide risk factors. Is able to include a risk assessment in the clinical interview although it is not well integrated. Is still developing familiarity with clinical resources and collaborative safety plans. Has an awareness of working with other treatment and service provider, such as inpatient and is gaining knowledge on procedures and policies for hospital admission or other continuing care.
R	☐	Unable to identify risk factors, including suicide related statistics for suicide or make clinical judgments based on these factors. Does not elicit risk or protective factors and has difficulty clearly documenting severity and safety plan.

SEEKS CURRENT SCIENTIFIC KNOWLEDGE (PWC – Research)

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

N/O	☐	Not Observed.
A/P	☐	Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.
I	☐	Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.
E	☐	Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.

R	☐	Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

CONSULTATION ASSESSMENT (PWC – Assessment)

Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.

N/O	☐	Not Observed.
A	☐	Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations.
P	☐	Chooses appropriate means of assessment to respond effectively to the referral question(s). Reports and progress notes are well organized and provide useful and relevant recommendations.
I	☐	Occasional input from supervisor is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question, with additional guidance required on complex cases.
E	☐	Needs continued supervision regarding appropriate assessment techniques to complete consultations as well as input regarding integration of findings and recommendations.
R	☐	Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.

CONSULTATIVE GUIDANCE (PWC – Consultation)

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/O	☐	Not Observed.
A/P	☐	Relates well to those seeking input, is able to provide appropriate feedback.
I	☐	Requires occasional input regarding the manner of delivery or type of feedback given, with additional guidance required on more complex cases.
E	☐	Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R	☐	Unable to establish rapport.

MILITARY BEARING (Program-Specific Competency)

Demonstrates proper military etiquette and follows protocol, consistently and effectively comports self as a professional military officer with a presence that instills confidence and solid interpersonal skills, demonstrates proper uniform wear, utilizes proper social skills in a formal military setting.

N/O	☐	Not Observed.
A	☐	Viewed by officers as the standard to which others should meet. Exudes a confident presence without being arrogant or aggressive. Places mission needs above own.
P	☐	Consistently follows military protocols and demonstrates appropriate officer comportment without prompting. Wears the uniform correctly. Able to adapt interpersonal style to formal and informal demands of different military settings. Respectful of all ranks and civilians.
I	☐	Generally follows military protocols and demonstrates appropriate comportment, with occasional on the spot correction and prompts by supervisors. Wear of the uniform is sufficient. Usually is able to distinguish between and adapt to formal vs. informal military setting demands. Officer is respectful of senior officers/civilians and progressing in learning how to supervise/be a role model to junior Service members.
E	☐	Inadequate comportment as a military officer usually demonstrated or egregious breeches in protocol/etiquette observed. Does not consistently wear the uniform properly. Does not consistently adapt interpersonal interactions to formal vs. informal military setting demands. Instances of disrespect have been reported.
R	☐	Does not observe military customs and courtesies, follow protocols, properly wear the uniform, or violates other aspects of appropriate officership. Instances of disrespect have been reported.

MILITARY FUND OF KNOWLEDGE AND APPLICATION TO PRACTICE (Program-Specific Competency)

Demonstrates appropriate breadth and depth of applicable military knowledge and is able to apply information to clinical practice. Functional military knowledge effectively informs clinical decision making, treatment plans, recommendations, referrals, consultation methods, etc.

N/O	☐	Not Observed.
A	☐	Demonstrates expansive functional knowledge of the military, expertly applies knowledge to clinical practice, and is called upon as a consultant on a variety of different topics and in multiple settings in military psychology.
P	☐	Able to consistently apply knowledge of the military and military culture to clinical practice without supervisor's assistance. Military knowledge is effectively combined with clinical practice to produce solid case conceptualization, treatment recommendations, clinical decision making, referrals, and consultation practices.
I	☐	Possesses basic understanding/knowledge of the military and military culture but requires routine supervision to supplement and expand fund of knowledge. Requires supervisor's assistance to apply military specific information to clinical practice.
E	☐	Insufficient knowledge of the military and does not consistently apply information to clinical practice.
R	☐	Unaware of or disregards military culture or protocol. Does not apply military knowledge to clinical practice.

SUPERVISOR COMMENTS

PERFORMANCE SUMMARY:

Click here to enter text.

AREAS OF CONTINUED PROFESSIONAL DEVELOPMENT, INCLUDING RECOMMENDATIONS:

Click here to enter text.

Trainee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Training Director Signature: _____ Date: _____

Walter Reed National Military Medical Center
Clinical Psychology Internship Program

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

Health Psychology Rotation

Trainee Name: Click here to enter text.

Supervisor Name: Click here to enter text.

Rotation: Choose an item. Choose an item.

Evaluation Period: Start Date: Click here to enter a date. **End Date:** Click here to enter a date.

ASSESSMENT METHOD(S) FOR COMPETENCIES

☐Direct Observation
☐Videotape
☐Audiotape
☐Case Presentation
☐Other: _____

☐Review of Written Work
☐Review of Raw Test Data
☐Discussion of Clinical Interaction
☐Comments from Other Staff

COMPETENCY RATINGS DESCRIPTIONS

A **Advanced/Skills comparable to autonomous practice at the licensure level.**

Rating expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however supervision is required while in training status.

P **Proficient/Occasional supervision needed.**

A frequent rating at completion of internship. Competency attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision**

Minimum rating for passing a rotation. Common rating throughout internship. Routine supervision of activities required.

E **Entry level/Continued intensive supervision is needed**

Required intensive supervision efforts are documented on the Individual Development Plan.

R **Needs remedial work**

Requires remedial work.

PROFESSIONAL INTERPERSONAL BEHAVIOR (PWC – Professional Values, Attitudes, and Behaviors)

Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.

N/O	☐	Not Observed.
A	☐	Smooth working relationships, handles differences openly, tactfully and effectively.
P	☐	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.
I	☐	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with rare interpersonal concerns with colleagues.
E	☐	Ability to participate in team model is limited, relates well to peers and supervisors. Requires intensive supervision (for a trainee at this level) to identify and or address interpersonal concerns with colleagues.
R	☐	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

SEEKS CONSULTATION/SUPERVISION (PWC – Communication and Interpersonal Skills)

Seeks consultation or supervision as needed and uses it productively.

N/O	☐	Not Observed.
A	☐	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms. Maintains excellent insight into personal strengths and limitations. Actively seeks assistance to improve areas of weakness and is effective in doing so.
P	☐	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, rarely over or under-estimates need for supervision. Maintains appropriate insight into personal strengths and limitations. Almost always seeks assistance to improve areas of weakness and is almost always effective in doing so.
I	☐	Generally accepts supervision well. Needs supervisory input for determination of readiness to try new skills. Generally aware of strengths and limitations and open to accepting feedback in these areas. Demonstrates ongoing efforts to improve areas of weakness.
E	☐	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
R	☐	Frequently defensive and inflexible, resists important and necessary feedback and/or lacks insight into personal limitations.

USES POSITIVE COPING STRATEGIES (PWC – Professional Values, Attitudes, and Behaviors)

Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.

N/O	☐	Not Observed.

A	☐	Good awareness of personal and professional problems. Stressors have minimal impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues. Routinely engages/employs effective positive coping strategies.
P	☐	Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact. Routinely engages employs effective positive coping strategies.
I	☐	Occasionally uses supervision time to minimize the effect of stressors on professional functioning. Able to successfully employ positive coping strategies to minimize effect of stressors on professional practice, with occasional prompting from supervisor. Accepts reassurance from supervisor well.
E	☐	Personal problems can significantly disrupt professional functioning.
R	☐	Denies problems or otherwise does not allow them to be addressed effectively.

PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION (PWC – Professional Values, Attitudes, and Behaviors)

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

N/O	☐	Not Observed.
A	☐	Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
P	☐	Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
I	☐	Uses supervisory feedback well to improve documentation. May require some feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
E	☐	Needs considerable direction from supervisor. May leave out crucial information.
R	☐	May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

EFFICIENCY AND TIME MANAGEMENT (PWC – Professional Values, Attitudes, and Behaviors)

Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

N/O	☐	Not Observed.
A	☐	Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

P	☐	Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner.
I	☐	Completes work effectively and promptly by using supervision time for guidance. Rarely needs reminders to meet deadlines.
E	☐	Dependent on reminders or additional deadlines to complete tasks.
R	☐	Frequently has difficulty with timeliness or tardiness or unaccounted absences are a problem.

KNOWLEDGE OF ETHICS AND LAW (PWC – Ethical and Legal Standards)

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

N/O	☐	Not Observed.
A	☐	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed
P	☐	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
I	☐	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
E	☐	Often unaware of important ethical and legal issues.
R	☐	Disregards important supervisory input regarding ethics or law.

EFFECTIVE COMMUNICATION (PWC – Communication and Interpersonal Skills)

Responsible for key patient communication tasks (e.g. phone calls, written correspondence, case management), and completes tasks promptly. Keeps supervisors aware of whereabouts as needed. Routinely communicates with faculty and supervisors when absences occur. Proactive and clear in communication style.

N/O	☐	Not Observed.
A	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. Routinely communicates proactively and effectively.
P	☐	Maintains regular and clear communication and coordination with faculty and primary supervisors. May occasionally require prompting to clarify issues, but quickly clarifies and effectively applies lessons learned in future settings.
I	☐	Mostly maintains clear communication with faculty and primary supervisors. Routinely requires prompting to clarify issues. Struggles to anticipate when/where proactive communication would assist in clinical duties.
E	☐	Needs considerable direction from supervisor. Routinely struggles to communicate effectively without prompting from supervisor.

R	☐	May seem unconcerned about proactive communication and coordination. Neglects to keep faculty and chain of command informed. Unresponsive to feedback.

PATIENT RAPPORT (PWC – Intervention)

Consistently achieves a good rapport with patients.

N/O	☐	Not Observed.
A	☐	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.
P	☐	Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.
I	☐	Actively developing skills with new populations and able to develop rapport with minimal supervision efforts. Relates well when has prior experience with the population.
E	☐	Has difficulty establishing rapport.
R	☐	Alienates patients or shows little ability to recognize problems.

SENSITIVITY TO PATIENT DIVERSITY (PWC – Individual and Cultural Diversity)

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

N/O	☐	Not Observed.
A	☐	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
P	☐	Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
I	☐	Resolves lack of knowledge with some patient groups effectively through supervision. Open to feedback regarding limits of competence.
E	☐	Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.
R	☐	Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND (PWC – Individual and Cultural Diversity)

Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.

N/O	☐	Not Observed.

A	☐	Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.
P	☐	Aware of own cultural background. Readily acknowledges own culturally-based assumptions.
I	☐	Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differences that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.
E	☐	Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and conceptualizations from culturally-based assumptions. Responds well to supervision.
R	☐	Has little insight into own cultural beliefs even after supervision.

MILITARY BEARING (Program-Specific Competency)

Demonstrates proper military etiquette and follows protocol, consistently and effectively comports self as a professional military officer with a presence that instills confidence and solid interpersonal skills, demonstrates proper uniform wear, utilizes proper social skills in a formal military setting.

N/O	☐	Not Observed.
A	☐	Viewed by officers as the standard to which others should meet. Exudes a confident presence without being arrogant or aggressive. Places mission needs above own.
P	☐	Consistently follows military protocols and demonstrates appropriate officer comportment without prompting. Wears the uniform correctly. Able to adapt interpersonal style to formal and informal demands of different military settings. Respectful of all ranks and civilians.
I	☐	Generally follows military protocols and demonstrates appropriate comportment, with occasional on the spot correction and prompts by supervisors. Wear of the uniform is sufficient. Usually is able to distinguish between and adapt to formal vs. informal military setting demands. Officer is respectful of senior officers/civilians and progressing in learning how to supervise/be a role model to junior Service members.
E	☐	Inadequate comportment as a military officer usually demonstrated or egregious breeches in protocol/etiquette observed. Does not consistently wear the uniform properly. Does not consistently adapt interpersonal interactions to formal vs. informal military setting demands. Instances of disrespect have been reported.
R	☐	Does not observe military customs and courtesies, follow protocols, properly wear the uniform, or violates other aspects of appropriate officership. Instances of disrespect have been reported.

MILITARY FUND OF KNOWLEDGE AND APPLICATION TO PRACTICE (Program-Specific Competency)

Demonstrates appropriate breadth and depth of applicable military knowledge and is able to apply information to clinical practice. Functional military knowledge effectively informs clinical decision making, treatment plans, recommendations, referrals, consultation methods, etc.

N/O	☐	Not Observed.
A	☐	Demonstrates expansive functional knowledge of the military, expertly applies knowledge to clinical practice, and is called upon as a consultant on a variety of different topics and in multiple settings in military psychology.
P	☐	Able to consistently apply knowledge of the military and military culture to clinical practice without supervisor's assistance. Military knowledge is effectively combined with clinical practice to produce solid case conceptualization, treatment recommendations clinical decision making, referrals, and consultation practices.
I	☐	Possesses basic understanding/knowledge of the military and military culture but requires routine supervision to supplement and expand fund of knowledge. Requires supervisor's assistance to apply military specific information to clinical practice.
E	☐	Insufficient knowledge of the military and does not consistently apply information to clinical practice.
R	☐	Unaware of or disregards military culture or protocol. Does not apply military knowledge to clinical practice.

DEMONSTRATE UNDERSTANDING OF SPIELMAN'S "3 P" MODEL OF INSOMNIA AND INTEGRATE THIS INTO CASE CONCEPTUALIZATION OF PATIENTS' PRESENTING SLEEP PROBLEM (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Proficiently understands and explains the "3 P" Model; can compare and contrast with other models of insomnia.
P	☐	Demonstrates understanding of model and appropriately frames patients' presenting sleep problem.
I	☐	Able to articulate a basic understanding of the model, though requires ongoing supervision with conceptualizing patients' sleep problem within the model.
E	☐	Emerging familiarity with the model, but unable to conceptualize patients' sleep problem within the model.
R	☐	Lack of understanding of the model and/or its relationship to the patients' presenting sleep problem.

DEMONSTRATE UNDERSTANDING OF THE 5 MAIN COMPONENTS OF CBT-I AND APPROPRIATELY PROVIDE OVERVIEW OF CBT-I TO THE PATIENT DURING INITIAL SLEEP ASSESSMENT (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Thorough understanding of the multi-component model, with clear and concise description provided to the patient.
P	☐	Understands the multiple components of the treatment and is able to describe each component clearly to the patient.
I	☐	With ongoing supervision, is gaining understanding of the CBT-I components, and is able to describe with occasional inaccuracies noted, the 5 components to the patient.
E	☐	Failure to identify CBT-I as a multi-component treatment model and/or difficulty in describing one or more of the components to the patient.
R	☐	Lack of understanding that CBT-I is a multi-component treatment model and inability to describe any/all of the components to the patient.

DEMONSTRATES UNDERSTANDING OF THE SLEEP DIARY AS A SELF-MONITORING TOOL AND IS ABLE TO ASSIST PATIENT WITH INITIATION OF THE DIARY (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Displays clear and concise description of the sleep diary, and is able to thoroughly explain the details of the diary to the patient.
P	☐	Demonstrates understanding of the clinical utility of the sleep diary and can clearly relate this to the patient.
I	☐	Demonstrates partial understanding of the use of the sleep diary and may have difficulty explaining to the patient.
E	☐	Limited understanding of the use of the sleep diary and/or inability to assist patient in initiation of a sleep diary.
R	☐	Lack of understanding of use of the sleep diary in CBT-I and/or inability to assist patient with initiation of a sleep diary.

DEMONSTRATE UNDERSTANDING OF SLEEP RESTRICTION AND IS ABLE TO DEVELOP AND MAKE ADJUSTMENTS TO AN SRT PROTOCOL WITHIN CBT-I TREATMENT (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Sets appropriate initial sleep prescription and demonstrates ability to make appropriate adjustments based upon patient's sleep diary data leading to patient improvement in limited time (ex. 4-6 weeks)

P	☐	Demonstrates ability to set appropriate initial sleep prescription, as well as appropriate shifts in prescription based upon patient's sleep diary data
I	☐	Partial understanding of SRT protocol and/or inability to make appropriate adjustments (ie. Sets changes too high or too low, leading to lack of patient improvement or prolonged time in SRT protocol)
E	☐	Demonstrates some familiarity with the SRT protocol, but is unable to apply this to patient care.
R	☐	Demonstrates lack of understanding of SRT protocol and is therefore unable to apply this to patient care.

SUPERVISOR COMMENTS

SUMMARY OF STRENGTHS:

Click here to enter text.

AREAS OF CONTINUED DEVELOPMENT, INCLUDING RECOMMENDATIONS:

Click here to enter text.

AREAS OF REMEDIATION, INCLUDING RECOMMENDATIONS:

Click here to enter text.

Trainee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Training Director Signature: _____ Date: _____

Walter Reed National Military Medical Center
Clinical Psychology Internship Program

PSYCHOLOGY TRAINEE COMPETENCY ASSESSMENT FORM

INPATIENT ROTATION

Trainee Name: Click here to enter text.

Supervisor Name: Click here to enter text.

Rotation: Choose an item. Choose an item.

Evaluation Period: Start Date: Click here to enter a date. **End Date:** Click here to enter a date.

ASSESSMENT METHOD(S) FOR COMPETENCIES

☐Direct Observation
☐Videotape
☐Audiotape
☐Case Presentation
☐Other: Click here to enter text.

☐Review of Written Work
☐Review of Raw Test Data
☐Discussion of Clinical Interaction
☐Comments from Other Staff

COMPETENCY RATINGS DESCRIPTIONS

A **Advanced/Skills comparable to autonomous practice at the licensure level.**

Rating expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however supervision is required while in training status.

P **Proficient/Occasional supervision needed.**

A frequent rating at completion of internship. Competency attained in all but non-routine cases; supervisor provides overall management of trainee's activities; depth of supervision varies as clinical needs warrant.

I **Intermediate/Should remain a focus of supervision**

Minimum rating for passing a rotation. Common rating throughout internship. Routine supervision of activities required.

E **Entry level/Continued intensive supervision is needed**

Required intensive supervision efforts are documented on the Individual Development Plan.

R **Needs remedial work**

Requires remedial work.

PROFESSIONAL INTERPERSONAL BEHAVIOR (PWC – Professional Values, Attitudes, and Behaviors)

Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.

N/O	☐	Not Observed.
A	☐	Smooth working relationships, handles differences openly, tactfully and effectively.
P	☐	Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns.
I	☐	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with rare interpersonal concerns with colleagues.
E	☐	Ability to participate in team model is limited, relates well to peers and supervisors. Requires intensive supervision (for a trainee at this level) to identify and or address interpersonal concerns with colleagues.
R	☐	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

SEEKS CONSULTATION/SUPERVISION (PWC – Communication and Interpersonal Skills)

Seeks consultation or supervision as needed and uses it productively.

N/O	☐	Not Observed.
A	☐	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms. Maintains excellent insight into personal strengths and limitations. Actively seeks assistance to improve areas of weakness and is effective in doing so.
P	☐	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, rarely over or under-estimates need for supervision. Maintains appropriate insight into personal strengths and limitations. Almost always seeks assistance to improve areas of weakness and is almost always effective in doing so.
I	☐	Generally accepts supervision well. Needs supervisory input for determination of readiness to try new skills. Generally aware of strengths and limitations and open to accepting feedback in these areas. Demonstrates ongoing efforts to improve areas of weakness.
E	☐	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.
R	☐	Frequently defensive and inflexible, resists important and necessary feedback and/or lacks insight into personal limitations.

PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION (PWC – Professional Values, Attitudes, and Behaviors)

Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.

N/O	☐	Not Observed.

A	☐	Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.
P	☐	Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.
I	☐	Uses supervisory feedback well to improve documentation. May require some feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.
E	☐	Needs considerable direction from supervisor. May leave out crucial information.
R	☐	May seem unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

KNOWLEDGE OF ETHICS AND LAW (PWC – Ethical and Legal Standards)

Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

N/O	☐	Not Observed.
A	☐	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed
P	☐	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.
I	☐	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input.
E	☐	Often unaware of important ethical and legal issues.
R	☐	Disregards important supervisory input regarding ethics or law.

SENSITIVITY TO PATIENT DIVERSITY (PWC – Individual and Cultural Diversity)

Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.

N/O	☐	Not Observed.
A	☐	Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
P	☐	Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.
I	☐	Resolves lack of knowledge with some patient groups effectively through supervision. Open to feedback regarding limits of competence.
E	☐	Is beginning to learn to recognize beliefs which limit effectiveness with patient populations.

R	☐	Has been unable or unwilling to surmount own belief system to deal effectively with diverse patients.

DIAGNOSTIC SKILL (PWC – Assessment; Intervention)

Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclatur and DSM. Utilizes historical, interview and psychometric data to diagnose accurately.

N/O	☐	Not Observed.
A	☐	Demonstrates a thorough knowledge of psychiatric classification, including relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.
P	☐	Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good.
I	☐	Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May occasionally miss relevant patient data when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.
E/R	☐	Has significant deficits in understanding of the psychiatric classification system and/or ability to Nuse DSM-V criteria to develop a diagnostic conceptualization.

PATIENT RISK MANAGEMENT AND CONFIDENTIALITY (PWC – Assessment; Intervention)

Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.

N/O	☐	Not Observed.
A	☐	Assesses and documents all risk situations fully prior to leaving the worksite forthe day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consults (as needed). Establishes appropriate short-term crisis plans with patients. Solid working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide.
P	☐	Recognizes and effectively manages safety issues. Appropriately documents risk. Initiates appropriate actions to manage patient risk. Promptly discusses confidentiality issues. Working knowledge of the DoD/VA Clinical Practice Guidelines on Assessment and Management of Patients at Risk for Suicide. Seeks supervision, as needed, with complex cases.
I	☐	Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. May occasionally need input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient. Needs prompting to utilize DoD/VA Clinical Practice Guidelines.
E	☐	Delays or forgets to ask about important safety issues. Does not document risk appropriately. But does not let patient leave site without seeking "spot" supervision for the crisis. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities in patient crises.

R	☐	Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor. Cannot apply DoD/VA Clinical Practice Guidelines in risk assessment.

CASE CONCEPTUALIZATION AND TREATMENT GOALS (PWC – Intervention)

Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.

N/O	☐	Not Observed.
A	☐	Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.
P	☐	Independently reaches a good case conceptualization within own preferred theoretical orientation. Readily identifies emotional issues. Sets appropriate goals and distinguishes realistic and unrealistic goals.
I	☐	Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.
E/R	☐	Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives impo1tant emotional issues. Unable to set appropriate treatment goals with patient.

SEEKS CURRENT SCIENTIFIC KNOWLEDGE (PWC – Research)

Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas.

N/O	☐	Not Observed.
A/P	☐	Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.
I	☐	Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.
E	☐	Open to learning, but waits for supervisor to provide guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding.
R	☐	Unwilling to acquire or incorporate new information into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.

CONSULTATIVE GUIDANCE (PWC – Consultation)

Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.

N/O	☐	Not Observed.
A/P	☐	Relates well to those seeking input, is able to provide appropriate feedback.
I	☐	Requires occasional input regarding the manner of delivery or type of feedback given, with additional guidance required on more complex cases.
E	☐	Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals.
R	☐	Unable to establish rapport.

IDENTIFIES VARYING ETIOLOGIES FOR COGNITIVE COMPLAINTS (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Based on real or hypothetical cases, identifies the most clinically relevant and significant aspects of a patient's complaints or symptoms. Systematically explores the clinical presentation, medical evidence, and psychosocial factors and identifies a number of plausible etiologies for a patient's symptoms. With minimal assistance, applies knowledge of cognitive processes and neurobehavioral syndromes to properly assess the likelihood of possible etiologies, either alone or in combination.
P	☐	Based on real or hypothetical cases, identifies most but not all of the clinically relevant and significant aspects of a patient's complaints or symptoms. Explores the clinical presentation, medical evidence, and psychosocial factors to identify at least one plausible etiology for a patient's symptoms and suggests none that is unreasonable. With assistance, applies knowledge of cognitive processes and neurobehavioral syndromes to assess the likelihood of proposed etiologies, either alone or in combination.
I	☐	Based on real or hypothetical cases, identifies many of the clinically relevant and significant aspects of a patient's complaints or symptoms. Explores the clinical presentation, medical evidence, and psychosocial factors to identify at least one plausible etiology for a patient's symptoms. May also propose etiologies that are unlikely but not groundless. With substantial assistance, applies knowledge of cognitive processes and neurobehavioral syndromes to assess the likelihood of proposed etiologies.
E	☐	Based on real or hypothetical cases, identifies some of the clinically relevant aspects of a patient's complaints or symptoms, but misses significant aspects. In a poorly organized manner, explores the clinical presentation, medical evidence, and psychosocial factors in an attempt to identify an etiology of a patient's complaints or symptoms. Proposes one or more unlikely etiologies that are weakly related to the data set. Even with substantial assistance, demonstrates a weak ability to apply knowledge of cognitive processes and neurobehavioral syndromes to assess the likelihood of possible etiologies.

R	☐	Based on real or hypothetical cases, identifies few of the clinically relevant aspects of a patient's complaints or symptoms. Fails to explore the clinical presentation, medical evidence, and psychosocial factors that might bear on the etiology of a patient's complaints or symptoms. Proposes very unlikely etiologies to explain the data set. Even with substantial assistance, is unable to apply knowledge of cognitive processes and neurobehavioral syndromes to assess the likelihood of possible etiologies.

FAMILIAR WITH THE CHARACTERISTICS OF LOSS OF CONSCIOUSNESS (LOC), ALTERATION OF CONSCIOUSNESS (AOC), AND POSTTRAUMATIC AMNESIA (PTA) AND THEIR RELATIONSHIP TO TBI SEVERITY RATINGS (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Can give detailed descriptions of LOC, AOC and PTA, and can identify subtleties in patients' descriptions of experiences that differentiate between LOC, AOC and PTA. The intern is able to correctly diagnose TBI severity without supervisor assistance and can accurately differentiate between LOC, AOC and PTA in all but the most complicated patient presentations, which may require some supervisory assistance.
P	☐	Can correctly differentiate between LOC, AOC and PTA as diagnostic criteria for TBI and can identify severity levels based on injury descriptions. The intern can extract injury characteristics during a clinical interview. They may need limited guidance/assistance differentiating between LOC, AOC and PTA from a supervisor.
I	☐	Can correctly differentiate between LOC, AOC and PTA as diagnostic criteria for TBI and can identify severity levels based on injury descriptions. The intern needs some limited supervisor guidance/assistance to extract injury characteristics during a clinical interview.
E	☐	Cannot fully differentiate between LOC, AOC and PTA as diagnostic criteria for TBI. The intern can differentiate TBI severity levels when given injury characteristics, but has difficulty extracting injury characteristics during a clinical interview without significant supervisor assistance.
R	☐	Unable to identify the diagnostic criteria for TBI (LOC, AOC, and PTA), does not assess for these characteristics during interview, and cannot accurately diagnose TBI severity when given injury details.

FAMILIAR WITH MEDICAL AND PSYCHOLOGICAL CONDITIONS THAT PRODUCE SYMPTOMS SIMILAR TO THOSE SEEN AFTER TBI (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Can describe several relevant medical and psychological conditions that have overlapping symptoms with mTBI/concussion symptoms and can present the relevant ones for the case at hand. Expresses an understanding in supervision of symptoms of acute TBI (all severity levels), those that may endure after TBI, and those not normally ascribed to a TBI. Able to explain this information to a patient during feedback independently on straightforward cases and with some supervisor interjection on complex cases.

P	☐	Can describe several relevant medical and psychological conditions that have overlapping symptoms with mTBI/concussion symptoms and can present the relevant ones for the case at hand. Expresses an understanding in supervision of symptoms of acute TBI (all severity levels), those that may endure after TBI, and those not normally ascribed to a TBI. Able to explain this information to a patient during feedback with supervisor interjection as needed.
I	☐	Can describe one or two medical and psychological conditions that have overlapping symptoms with mTBI/concussion symptoms but needs assistance in supervision with presenting the relevant ones for the case at hand. Can express a basic understanding in supervision of symptoms of acute TBI (all severity levels), those that may endure after TBI, and those not normally ascribed to a TBI. Unable to very minimally explain this information to a patient during feedback.
E	☐	Unable or can only very minimally describe medical and psychological conditions that have overlapping symptoms with mTBI/concussion (describes cognitive symptoms in the context of a mTBI/concussion without understanding that other medical and psychological conditions cause similar cognitive symptoms). Unable to express an understanding, either in supervision or in the feedback session with the patient of the symptoms of acute TBI (all severity levels), those that may endure after TBI, and those not normally ascribed to a TBI.
R	☐	No understanding of the fact that medical and psychological conditions have overlapping symptoms with mTBI/concussion. Unable to express an understanding of common symptoms after a TBI of any severity level.

CAN EXPLAIN THE TYPICAL RECOVERY CURVES ASSOCIATED WITH DIFFERENT TBI SEVERITIES (Program-Specific Competency)

N/O	☐	Not Observed.
A	☐	Achieves level 'P', can further identify and discuss at least three non-TBI factors that can impact the predicted recovery curves when considering the recovery of individual patients, and can discuss potential ways that such factors could impact treatment and eventual recovery outcome.
P	☐	Accurately describes and draws the basic recovery curves (discriminating between mild, moderate and severe injury recovery curves), during the feedback portion of the interview is able to explain this information to patients with differing levels of TBI severity, and can apply relevant recovery curve information in relation to the patient's specific complaints for improving patient's understanding of ongoing symptom concerns.
I	☐	Accurately discusses what is meant by basic recovery curves, can discriminate mild, moderate and severe injury recovery curves based on visual recognition and with minimal supervisor assistance is able to explain relevant recovery curve information to patients with different levels of TBI severity during feedback.
E	☐	Understands what is meant by recovery (improving performance over time) but cannot explain differences in the recovery trajectories between mild, moderate and severe traumatic brain injury.
R	☐	Unable to describe any recovery curve information or can only minimally describe it.

SUPERVISOR COMMENTS

PERFORMANCE SUMMARY:

Click here to enter text.

AREAS OF CONTINUED PROFESSIONAL DEVELOPMENT, INCLUDING RECOMMENDATIONS:

Click here to enter text.

Trainee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Training Director Signature: _____ Date: _____

Tri-Service IBHC Core Competency Tool

V2.0 24Sep15

IBHC: **Date:** **Trainer:** **Training Phase: I or II or Other**

Certified IBHC Trainer rates the IBHC trainee skill level based on their observations of each dimension. Trainees must demonstrate ability to perform the minimal benchmark behaviors and/or other clinical knowledge/skill that is consistent with minimal benchmark. **A "Pass" rating on every element is required to satisfactorily complete training.**

For Phase I Training, only unshaded items will be rated. A trainer must observe a minimum of 4 new patient appointments (role play or in vivo).

For Phase II Training, all items (shaded and unshaded) will be rated. A minimum of 8 patient appointments (in vivo, including 5 new patient appointments) and a minimum of 5 PCM consultative feedback interactions must be observed. All IBHC chart notes for patients seen during Phase II training must be reviewed, along with an additional 5 chart notes from prior appointments.

NOTE: IBHCs are expected to have foundational skills in evidence-based assessment, treatment, consultation, and documentation through their graduate education and post-licensure work experiences. These prerequisite skills are NOT comprehensively taught during the Phase I IBHC training course. A strong foundation in these areas is typically necessary to successfully acquire and demonstrate the competencies required to function as an IBHC as assessed during the Phase I and II evaluations.

Dimension: I. Clinical Practice Knowledge and Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. **Role definition**: *Says introductory script smoothly; conveys the IBHC role to all new patients.*	1a. Accurately describes per standardized script: i) Who they are and their role in the clinic ii) How long the appointment will be, iii) What will happen during the appointment, iv) What types of follow-up might occur, v) That the appointment note will go in medical record, vi) That the PCM will get feedback, vii) Any reporting obligations.				
	1b. Delivers the script in 2 minutes or less.				
	1c. If interrupted by the patient during the introductory script, the IBHC answers questions and appropriately redirects to complete the introductory script.				
2. Rapid problem identification: *Rapidly reaches agreement with the patient on identifying the primary problem.*	2. Confirms and clarifies consultation issue and obtains initial patient engagement in addressing consultation issue within 60 seconds after completing the introductory script.	• "It looks like Dr. Hunter would like me to assist the two of you in better managing or targeting your depressed mood. Is that what you see as the main problem or is it something different?" • "I've read Dr. Hunter's note but want to make sure we are all on the same page. Before we get started on our appointment, what is the problem that you're here to address?"			

Dimension: I. Clinical Practice Knowledge and Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
3. Assessment: *Focused on presenting problem, uses a biopsychosocial assessment approach to assess current functioning, symptoms and quality of life.*	3a. Assessment of functioning: Asks questions appropriate to the presenting problem about how the following are influencing the identified problem and patient's functioning in the home, social, work, recreational, and spiritual areas of life: i) physical condition/physical response, ii) behaviors/habits, iii) thoughts, iv) emotions, v) environment/social interactions.				
	3b. Assessment of symptoms: Uses assessment measures appropriate to primary care (BHM-20 for every patient every appointment). If additional measures (e.g., PHQ-9, GAD-7) are administered, they are appropriate for primary care, scored, interpreted, and documented correctly.				
	3c. Asks about duration, frequency and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem. Asks about biopsychosocial factors that coincided with onset of or change in symptoms.	• "How long have you been feeling depressed?" • "How many days per week are you feeling down?" • "When during the week have you noticed that this is NOT a problem or is NOT occurring?" • "On a scale of 0-10 with 0= not feeling depressed at all and 10= the most depressed you've ever felt, over the last two weeks what would be the average number for how you've felt?....what is the highest it has been in the last two weeks?....what is the lowest it has been?"			
	3d. Appropriately assesses and manages risk of harm to self/others: i) Assesses SI and HI verbally at every initial visit, ii) At follow-up appointments, assesses SI and HI in accordance with Service-specific standards, iii) Initiates appropriate disposition for patients with elevated risk, following Service-specific guidance.	Does not routinely attempt to maintain higher risk patients in primary care consultation and makes efforts to elevate high risk patients to specialty care in a timely manner.			

Dimension: I. Clinical Practice Knowledge and Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
4. Problem focus	4a. Limits problem definition/assessment (focuses on presenting problem). Does not assess other areas (except suicidal and homicidal ideation) until assessment of initial referral problem is complete and as time allows. Exceptions may be made when a patient clearly indicates a preference for talking about a different problem area and an unwillingness to discuss referral problem.	After data for presenting problem is collected, IBHC might opt to assess other areas identified or suspected as problematic: For example, for a patient presenting with anxiety problems: "You mentioned that gaining weight has also been a problem for you. How much weight do you think you've gained in the last year?"			
	4b. Completes focused assessment in 15 minutes or less for 75% of new appointments.				
5. Summary and formulation	5. Provides patient succinct summary of assessment information and biopsychosocial impressions/formulation of problem. Appropriately integrates key biological, psychological, social, or environmental factors in the formulation. Summary and formulation takes 1-3 minutes and occurs between the assessment and intervention phases of appointment.	Summary includes key symptoms and functional impairment. Formulation includes discussion of biological, behavioral, cognitive, emotional, and/or environmental factors that led to (or maintain) the problem. Example: discusses potential links between medical problems or medications and mood; environmental factors and sleep; cognitions and emotions.			
6. Population-based care[1]	6a. Able to verbally describe principles of population-based care, such as timely access to care, viewing PC panel as his/her own panel, value of prevention and early intervention, and stepped care approach.				

[1] ***Population-based care*** *is defined as an approach that allows one to assess the health status and health needs of a target population, implement and evaluate interventions that are designed to improve the health of that population, and efficiently and effectively provide care for members of that population in a way that is consistent with the community's cultural, policy, and health resource values.*

Dimension: I. Clinical Practice Knowledge and Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
6. Population-based care (continued)	6b. Performs needs analysis[2] (working collaboratively with PCMH staff members or other MTF resources as needed) to identify defined sub-populations of enrolled beneficiaries who might benefit from an IBHC appointment. Reviews data from needs analysis with PC leadership and proposes an implementation plan incorporating a PCBH clinical pathway for one or more of the conditions identified as a priority by the needs analysis.	Obtains assistance from practice manager, clinic leadership, or population health personnel, to generate list (through AHLTA or Carepoint data pull) of top 5 medical conditions seen in clinic (e.g., chronic pain, uncontrolled diabetes, obesity). Prioritizes conditions with behavioral health components. During discussion of needs analysis with leadership, IBHC reviews DoD PCBH clinical pathways as an option for improving population health.			
7. Biopsychosocial approach: *Understands relationship of medical and psychological aspects of health (e.g. biopsychosocial model of physiological disorders)*	7. Describes to the patient the relevant factors (physical, behaviors, thoughts, environment, interactions with others) impacting symptoms and functional impairments.	Articulates that thoughts can lead to changes in emotions, physiology, behaviors. Articulates that engagement in behaviors can impact thinking, emotions, physiology. Articulates that changes in physiology can lead to changes in behaviors, emotions and thinking. • "When people have thoughts like yours, that can lead to direct physical changes like increased heart rate, blood pressure and muscle tension, which can lead to prolonged feelings of stress/anxiety, decreased social interactions (just don't feel like it), and work performance (can't concentrate). This can also interfere with your ability to get restful sleep which then may further impact mood, energy and concentration."			

[2] ***A needs analysis*** *is the process of identifying and evaluating needs in a community or other defined population of people. The identification of needs is a process of describing "problems" of a target population and possible solutions to these problems.*

Dimension: I. Clinical Practice Knowledge and Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
8. Uses evidence-based recommendations and interventions suitable for primary care for patients and PCMs.[3]	8a. For Phase I training, IBHC can demonstrate **at least 2 of the following interventions** in the categories below: Phase II training must demonstrate at **least 3 of the following** in the categories below: i) Adapted cognitive interventions, ii) Adapted behavioral interventions, iii) Adapted physiological management Interventions (e.g., relaxation training), iv) Adapted Motivational Interviewing (MI) interventions, v.) Acceptance and Commitment Therapy (ACT) interventions.	• Adapted cognitive interventions: Questioning unhelpful thinking, developing new ways to think that are consistent with values and goals. • Adapted behavioral interventions: Behavioral activation, behavior change to improve management of sleep, effectively target chronic pain, diabetes, obesity, tobacco use, EtOH use, communication skills training. • Adapted physiological management interventions: Relaxed breathing, cue controlled relaxation, imagery, progressive muscle relaxation, distraction. • Adapted MI interventions: Using decisional balance, emphasizing personal choice, eliciting change talk, using readiness ruler, developing a change plan.			
	8b. Interventions are specifically (operationally) defined and supportable by primary care team members.	• Increase fun activities (dinner with friend 1x/wk). • Increase exercise (Mon-Fri from 1700-1730, 30-minutes on stair-stepper). • Use relaxation skills (deep diaphragmatic breathing, starting at bedtime).			
	8c. Interventions are collaboratively developed with the patient.				
9. Intervention design	9a. Designs interventions to improve functional outcomes and /or reduce symptoms measurably.	Intervention is targeted to improve an objective functional outcome or symptom. Changes are measured through self-report of frequency or duration, report of intensity/quality using 0-10 rating scale, standardized assessment measure, etc. • Decrease work absenteeism. • Finish specific work tasks by the end of work day • Improve performance on specific responsibilities at home. • Increase frequency of social interactions. • Increase exercise, enjoyable or spiritual activities. • Improve sleep duration, efficiency or decrease time to sleep onset. • Decrease pain exacerbation, improve mood.			

[3] See *Hunter, Goodie, Oordt, & Dobmeyer* (2009) for examples of adapted evidence-based primary care appropriate interventions.

Dimension: I. Clinical Practice Knowledge and Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
9. Intervention design (continued)	9b. Uses self-management, home-based practice as the prime method for intervention. The majority of intervention is done by patient outside of the consultation appointment.	Examples: Deep breathing, cue controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, eating behavior changes, increased physical activity, problem solving, and assertive communication.			
10. Psychoeducation Class Skills	10. Provide classes and/or group medical appointments with a format and content appropriate for primary care. Minimum of 1 class must be scheduled within the first twelve weeks of being in clinic full time.	• Sleep enhancement class • Relaxation class • Drop-in stress management class • Group medical visit for chronic condition • Classes consistent with any of the IBHC clinical pathways			
11. Pharmacotherapy	11a. Can identify common psychotropic medications, the indications for the medication, and common side effects. Can address common myths about psychotropic medication.				
	11b. Knows indications for medications frequently prescribed for health conditions commonly treated in PC.				
	11c. Seeks additional information on psychotropic medications from appropriate sources when needed (e.g., EBHC, PCM, reference material).				
	11d. Stays within professional license and scope of practice for non-prescribers. IBHCs who hold prescription privileges do not prescribe.				

Dimension: II. Practice Management Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Visit efficiency	1. Uses 30-minute appointment efficiently.	Identifies problem, conducts assessment, summarizes understanding of problem at approximately the 15 minute point, and uses the next 10 minutes to develop a behavioral change plan.			
2. Time management	2a. Appointments are kept to 30 minutes or less. **Phase I training standard**: At least 50% of appointments are completed within 30 minutes on the final training day. **Phase II training standard**: At least 85% of appointments are completed within 30 minutes.				
	2b. Keeps on schedule with consecutive appointments.	If one appointment runs 5 minutes long, the IBHC compensates by shortening future appointments (as appropriate) in order to maintain schedule.			
3. Follow-up planning	3a. Appointments are spaced in a manner consistent with a population-health model as well as individual patient needs. Schedules weekly follow-up intervals only when clinically indicated.	• Plans follow-up for two weeks or one month, instead of every week. • Schedules less than 2 week follow-up as indicated; e.g., a depressed patient with mild risk of self-harm; patient with daily panic attacks; patient needing bridging care during interval to specialty care appointment, etc.			
	3b. Spaces out IBHC appointments by alternating follow-ups with other members of PC team (e.g., PCMs, BHCFs, dietitian).				
4. Intervention efficiency	4a. Sees most patients for 4 or fewer appointments per episode of care.				
	4b. Structures behavioral change plans consistent with time-limited treatment (i.e., selects interventions that reasonably can be implemented in 4 or fewer appointments).				

Dimension: II. Practice Management Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
6. Triage	6a. Demonstrates knowledge and clinical judgment in determining which patients need referral to specialty mental health. Uses a stepped-care approach.	• Provides IBHC intervention over several appointments, assesses progress, recommends referral to specialty mental health if additional care needed. • Encourages referrals for patients with a high severity level of symptoms and low functioning, higher risk category for risk to self or others, alcohol dependence, manic or psychotic symptoms.			
	6b. Provides intervention for most common mental health and medical conditions in primary care, recommending specialty mental health care only when indicated.				
7. PCBH care coordination	7a. IBHC and BHCF staff shared patients (and potentially shared patients) at least weekly (N/A if no BHCF).				
	7b. Refers patients with depression and/or anxiety to BHCF for care facilitation services, when indicated.	Patients with depression or anxiety who are not yet receiving BHCF services.			
	7c. Able to describe the role of the EBHC and identify the EBHC for their clinic.				
8. Community and military resource referrals	8. Has information on military installation resources and community-based resources, and refers patients when indicated.	• Family support services, deployment-related support groups, chaplaincy services, childcare options, legal assistance, etc. • Local support groups, civilian credit or finance counseling, community centers, senior centers, health promotion organizations, etc.			
9. Continuity Consultation	9a. Provides continuity consultation to patients with chronic conditions or high medical utilization who might benefit from ongoing, periodic consultation with the IBHC.	Patients with obesity, diabetes, chronic pain, etc., seen monthly or quarterly for monitoring progress and reinforcing long-term behavior change plans.			
	9b. Continuity consultation visits focus primarily on monitoring progress, reinforcing behavior change plans, maintaining gains, and preventing relapse.	Continuity consultation is not provided for the purposes of providing long-term psychotherapy.			
	9c. When continuity consultation occurs, the IBHC documents the rationale in medical record.	"Patient seen for continuity consultation to promote longer-term adherence to recommended lifestyle changes for diabetes management."			

Dimension: III. Consultation Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Referral clarity	1. When referral question is unclear, seeks clarification from referring medical note, PCM, and/or patient.				
2. Curbside consultations	2a. Available for "on demand" consultation requests from PCMs, BHCFs, and other PCMH staff.	• When IBHC is with a patient and PCM knocks on door to speak about another patient, IBHC briefly steps out of office to meet with PCM for 1 to 2 minutes to address PCM's concerns. • IBHC does not use a "do not disturb" sign on door.			
	2b. Clearly and concisely provides assessment results and recommendations in response to PCM "curbside consultation" request. Typically this is no more than 3 minutes. Often includes specific recommendations for PCM's course of action with a patient.	Example: PCM approaches about a patient who has been asking for a third renewal of zolpidem. Although you're running a few minutes behind, you step into the PCM's office to provide brief consultation based on your recent appointment: "Mrs. S's sleep problems haven't improved. This seems related to her difficulty giving up her daytime naps. Although she wants more zolpidem, I'd recommend you encourage her to follow through on her plan to eliminate naps and get up at the same time each morning. You could also remind her stop at the desk to schedule her follow-up with me."			
3. Verbal consultative feedback	3a. Provides same-day verbal feedback to PCMs for every appointment, unless PCM requests alternate method and/or frequency. If PCM is not available for same-day verbal feedback, IBHC uses alternate means to provide feedback.	Alternate means for feedback could include secure email, secure messaging, tracking function in AHLTA, copy of written note.			
	3b. PCM feedback is concise (less than 3 minutes), avoids jargon, and includes the IBHC's problem assessment, the behavior change plan, and recommendations for PCM's care of the patient.				
4. Assertive follow-up with PCMs .	4a. Interrupts PCM/team member when needed to address urgent patient needs. Interruptions are kept as brief as possible to minimize impact on PCM workflow.	Examples of urgent patient needs: Concerning medication side effects, urgent patient questions regarding medications or medical recommendations, safety concerns.			
	4b. Avoids interrupting PCMs for non-urgent needs. Uses other PC team members when appropriate for non-urgent issues. Other PC team members include nurses, med techs, admin assistants, etc.	Examples of non-urgent needs: Questions regarding appointment scheduling, routine medication refill requests, etc.			

Dimension: III. Consultation Skills (continued)					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
5. PCM education: *Educates primary care staff on how to optimally use IBHC services.*	5a. Clearly articulates the following via formal and informal avenues (curbside consultations; i.e., informal or unofficial consultations): i) IBHC visit expectations (25 minute consultations, brief episodes of care), ii) referrals (emphasizing what conditions and when to refer), iii) how to best use IBHC (alternating appointments to reduce high utilization, teaming up for continuity consultation for chronic medical conditions).	Examples of formal avenues: PCMH staff meetings/briefings, EMR notes. Example of informal avenue: Curbside consultations (*see Element III, 2b – Consultation Skills*)			
	5b. Provides training to PCMH team members on role of IBHCs in addressing behavioral health concerns.				
6. Value-added recommendations: *Recommendations are tailored to the pace of primary care.*	6. Provides PCMs with patient recommendations that the PCM could implement with the patient in 3 minutes or less and are intended to reduce PCM visits and workload. Recommendations are: i) achievable for the patient, ii) evidence-based, iii) brief (explained in less than 3 minutes), iv) concrete, and v) intended to reduce PCM visits and workload.	Example of reducing PCM visits and workload: Follow-up with IBHC instead of PCM			

Dimension: IV. Documentation Skills					
Element	**Minimal Demonstrated Benchmark Behaviors**	**Sample Behavioral Anchors**	**Skill Rating**		**Comments**
			Fail	**Pass**	
1. Concise, clear charting using appropriate format	1a. IBHC-specific AHLTA template is used.	Example of appropriate AHLTA template: TSWF-IBHC AIM form.			
	1b. Documentation is initiated in the medical record during the clinical encounter.				
	1c. Clinical notes are written specifically for PCM and team members in a succinct and jargon-free manner.	See examples in service clinic practice manuals.			
	1d. Documentation includes pertinent history of presenting problem, focused review of systems and MSE, information on functional impairment, and clear clinical impression with specific evidence-based recommendations and follow-up plan for patient and PCMH team.				
	1e. Ensures AHLTA notes are accessible to the PCMH team and maintained as part of the patient's medical record.	Example: Avoiding restrictive demarcations, such as checking the box to make the note "sensitive," which is in most cases, not appropriate for primary care.			
2. Written recommendations to PCM: *Written feedback provided to PCM and team members.*	2a. Completes at least 80% of clinical notes by the end of the same day the patient is seen. Completes 100% of notes within 24 hours of patient's appointment.				
	2b. Content of clinical note is succinct and tailored to the PCM, and avoids psychological jargon.				
	2c. Written recommendations are actionable by PCM while not adding significantly to PCM's existing workload.				

Dimension: V. Administrative Knowledge and Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. IBHC policies and procedures: *Uses appropriate scheduling, templates, and coding for PCMH work.*	1a. Ensures their template is structured to allow for flexibility of scheduling: i) includes time for same-day/walk-in appointments in daily schedule/template, ii) adjusts template based on clinic needs and patient flow, iii) continues to meet the requirement of service- specific available appointments (e.g., minimum of 10 slots per day).				
	1b. Uses appropriate MEPRS code, reflecting primary care work.				
	1c. Uses correct CPT and/or E/M codes in accordance with Service clinical practice manual.	Example of appropriate codes: Health and Behavior procedure (CPT) codes, E/M codes Examples of inappropriate codes: Any CPT code indicating out-of-scope practices (e.g., formal assessment, review of records, etc.).			
	1d. Ensures templates reflect appropriate timeframes for appointment type: i) individual and couple appointment slots are no more than 30 minutes, ii) class length appropriately reflects content.	Examples of appropriate content/timeframe: • 30 minute relaxation class • 60 minute sleep enhancement class • 90 minute shared medical appointments			
	1e. **DoD IBHC peer review items are used in regular peer review process**.				
2. Risk-management protocols	2a. Accurately describes informed consent procedures in primary care behavioral health consultation to patients.				
	2b. Appropriately uses risk pathways in primary care and any involvement with specialty mental health clinics and/or emergency departments as applicable, as outlined by service specific SOPs.	Examples of specific SOPs addressing risk pathways: • Service practice manuals, relevant service regulations, instructions, etc.			
	2c. Works with PC leadership to formally outline risk assessment, management, and treatment appropriate to PCBH, including writing specific guidelines with detailed pathways/resources.				

Dimension: VI. Team Performance Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Fit with primary care culture	1a. Knows the roles of the various primary care team members and articulates their roles/duties in the clinic.	• Group practice manager • PCMs (i.e., physicians, PAs, NPs) • Nurses • Administrative staff • BHCFs			
	1b. Regularly (90% of clinic meetings) participates in PC staff meetings, huddles, and appropriate events to stay a visible and active member of the team, providing ongoing consultation and education about PCBH services.				
	1c. Uses language and practice habits appropriate for PC culture.	• Avoids specialty MH jargon (e.g., "session," "therapy," "processing," or "group"). Instead, uses terms such as "appointment," "visit," or "classes" to be consistent with PC consultation. • Uses PC space for consultation (e.g., exam room). • Avoids creating unique space akin to specialty MH clinics that are out of the norms of a typical PC clinic, thus promoting a message of "different/ specialty service" (e.g., dim lighting, specialty furniture not found in other PC exam rooms/offices, incense/candles, white noise machine, "do not disturb" sign).			
2. Responsiveness and availability to PC team	2. Maintains flexible attitude and openness in providing consultation: i) Readily provides unscheduled services when needed; ii) Has an "open door" policy encouraging PCMH staff interruptions to promote same-day visits and curbside consultations.	• When not seeing patients, actively engages with PCMH team members to encourage referrals. • Door is literally open when not seeing patients. • Does not use a "do not disturb' sign.			

<u>Phase I Training</u>
Successful completion requires ***<u>all unshaded items</u>*** rated as "Pass"
CIRCLE: PASS / FAIL - (Provide rationale in comments.) Date of completion: _____

Trainer's signature: _____ IBHC's signature: _____ Date:_____

Phase II Training

Successful completion requires ***all items (shaded and unshaded)*** rated as "Pass"

CIRCLE: PASS / FAIL - (Provide rationale in comments.) Date of completion: _____

Trainer's signature: _____ IBHC's signature: _____ Date:_____

COMMENTS: