

Mt. Sinai St. Luke's and West Hospitals
Psychology Internship Program Handbook
2019-2020

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Mount Sinai St. Luke's and West Hospitals Psychology

Internship Program General Guidelines

The following general guidelines outline the 'basics' of daily life for interns in the Department of Psychiatry at Mount Sinai St. Luke's and West Hospitals. Also provided in this Handbook, are the descriptions of the major Department services, and contact information for key staff in the intern's daily life.

INTERNSHIP PHILOSOPHY AND GOALS

The Mount Sinai St. Luke's and West Hospitals Psychology Internship Program is fully accredited by the APA and as such, offers broad-based, generalist training in clinical psychology as practiced in a modern, urban hospital center. The Internship has two overarching goals: (1) Development of each intern's professional judgment, proficiency, and identity, through experience with a wide variety of patients and treatment settings; and (2) Development of each intern's ability to be an independent, skilled, conceptually-based, and empathic clinician - with a keen sense of the role of ethnic, cultural, and contextual factors in individuals' lives.

Aims and Competency Development

In facilitating interns' proficiency to function as independent, generalist psychologists, the Internship Program is dedicated to developing certain core competencies. These are competencies in: (1) research skills; (2) ethical and legal standards; (3) multicultural awareness; (4) professional values, attitudes and behaviors; (5) communication and interpersonal skills; (6) assessment skills; (7) models for intervention including evidence-based methods; (8) supervision skills, and (9) consultation and inter-professional/interdisciplinary skills.

Training in various diagnoses and modalities of evidence-based psychotherapy and assessment is integral to this process. An integrative treatment approach – combining psychodynamic, cognitive behavioral, systems, ethno-cultural, developmental and medical model perspectives -- is emphasized. This approach is taught, and practiced by psychology interns, throughout the various clinical placements and didactics. Within this approach, an attempt is made to individually tailor each intern's experience in accordance with his/her interests and goals. Ongoing program planning and evaluation involving the interns and their supervisors are an integral part of the program. Interns are encouraged to assume a gradually increasing degree of professional responsibility and autonomy as the year progresses.

The Internship Program is guided by the tenets of the practitioner-scholar model. Our primary focus is on developing the intern's capacities to deliver clinical psychological services. This is implemented through supervised clinical experience and courses. Empirical and theoretical psychological literature is the core of our experiential and didactic training. Thus, we emphasize evidence-based intervention and assessment, empirically-validated psychological theory, and methods of scientific inquiry and analysis in our training and services. As Rodolfa et al. (2005) observe: the practitioner-scholar model 'emphasizes the development of reflective skills and multiple ways of knowing in the practice of psychology, and it stresses clinical practice and the importance of theory and the use of research to

inform practice'. (Rodolfa, E. et al., 2005, Internship training: Do models really matter? Professional Psychology, Research and Practice, 36(1), 25-31).

INTERNSHIP PROGRAM DESCRIPTION

The Internship is a two-track (i.e., Child and Adult Track) program, housed in the Psychology Education and Training Division of the Department of Psychiatry and Behavioral Health. At the time of application, each intern applies to either the Adult or Child Track. There are five Adult Track and four Child Track interns. Both tracks are anchored in the Program's core commitment to integrationist philosophy, evidence-based evaluation and intervention, and ethno-cultural competence. Both tracks offer training in intervention and assessment. Both tracks embrace a highly participatory teaching style - in shared and separate core courses. Both tracks are staffed by some common and some distinct Faculty. Both tracks place interns in clinical services for periods generally between two months and one year. Within each clinical rotation, interns have an opportunity to develop their skills in various forms of evaluation and treatment. This allows them to gain clinical experience with patients from different ethnic and socioeconomic backgrounds with a wide range of psychopathology, as well as to learn about treatment systems by becoming an integral member of a treatment team. With one exception (i.e., Comprehensive Adolescent Rehabilitation and Education Service, or CARES), the two tracks use different clinical rotations -- to provide relevant clinical experience with their respective populations.

ROTATIONS

The following is a list of the treatment clinics where the Mount Sinai St. Luke's and West Clinical Psychology Internship training program operates and where the service recipient populations are treated. It should be noted that this list describes diagnostic diversity, but the populations in all clinics here listed are diverse and multicultural, in a variety of ways, including but not limited to race, gender, sexual orientation, age, SES, religion and disability.

a.) CITPD (Center for Intensive Treatment of Personality Disorder) which treats character pathology (mainly Narcissistic Personality and Borderline Personality) using a DBT-informed model as originally delineated by Marcia Linnehan, Ph.D combined with more traditional psychodynamic and psychoanalytic treatment modalities. These evidenced- based models offers our interns a scholar-practitioner approach to the treatment of a complex, often hard to treat, population.

b.) Psychiatric Recovery Center which treats Severe Mental Illness using integrative techniques including SIPs evaluation methods and CBT for psychosis. Here again, interns are taught state of the art, evidenced based approaches to the treatment of a challenging patient population.

c.) The Addictions Institute which treats dually-diagnosed adult patients using an approach which is based in the Harm Reduction Model. While other addictions models (such as the 12 step approach) are reviewed and discussed, the Harm Reduction Model and the clinical evidence on which it is based, serves as the back-bone of the treatment in this training clinic.

d.) An adult psychiatric inpatient units where adult in acute crisis suffering from a broad range of DSM-V diagnoses are treated. Here trainees learn to evaluate and diagnose a broad range of DSM-V diagnoses in diverse populations.

e.) |An Adult Outpatient clinic where psychiatric outpatients with a broad spectrum of DSM-V diagnoses are treated. Here interns are trained in a number of evidence based approaches to the treatment of patients including: DBT, CBT for Depression, CBT for Panic Disorder and GAD, CBT for OCD, CBT for Social Anxiety, and Motivational Interviewing. In the supervision of each case, an effort is made to adapt each protocol in a patient-specific fashion.

f.) A Comprehensive Adolescent Rehabilitation and Education Service (CARES) which is a therapeutic school embedded in a milieu treatment unit that treats dually-diagnosed, at risk high school students. At CARES, interns are immersed in two primary evidence-based approaches that are integrated throughout the program: Dialectical Behavior Therapy and Motivation Enhancement Therapy. Interns are also exposed to evidence based trauma informed treatments (e.g. Trauma-Focused CBT, Seeking Safety) as well as CBT and psychodynamic approaches to treating severe pathology in adolescents.

g.) A Child Outpatient Department (OPD) where children, adolescents and families with a broad range of DSM-V diagnosis are treated. In the Child OPD, interns are trained in a variety of evidence-based treatments for children and adolescents including: CBT for Depression and Anxiety Disorders, DBT for Adolescents, Parent Management Training, Trauma-Focused CBT and Parent-Child Psychotherapy, amongst others. Interns are supervised by staff psychologists skilled in evidence-based psychodynamic and cognitive behavioral interventions for children and their families.

h.) An inpatient child/adolescent psychiatry unit where children and adolescents in acute phases of major psychiatric illness are treated. On the unit, interns are trained extensively in risk assessment, safety planning and diagnostic assessment based on DSM-V diagnoses.

i.) A pediatric neuropsychology assessment service where interns observe and conduct psychiatric assessments of children and adolescents. On this service, interns learn how to administer, score and interpret a wide range of evidence-based tests for children and adolescents. They also build and refine skills in writing comprehensive neuropsychological assessments.

PSYCHIATRIC EMERGENCY DEPARTMENT MINI-ROTATION

For interns in both Tracks, we offer an optional mini-rotation in the Psychiatric Emergency Department. On a customized basis, interns can join the Psychiatric Emergency Department team. They receive on-the-job training in crisis assessment, diagnostic interviewing, and treatment planning, with acute and sub-acute adults, adolescents and children. Interested interns can participate in this mini-rotation only if the Training Director or Associate Training Directors and the Director of the Psychiatric Emergency Department agree that he/she has sufficient time to do so.

OUTPATIENT PSYCHIATRY CLINIC EXPERIENCE

For interns in both Tracks, outpatient individual, group, and family therapy is a year-long rotation, which is a major component of the Internship clinical experience.

ADULT TRACK

In the Adult Outpatient Clinic, each intern carries a caseload of: 8-10 individual patients, one group and one family, with a broad range of psychiatric diagnoses, demographic characteristics, and ethnic, cultural and sexual identities, and life situations. Interns receive supervision in each of the following areas: group psychotherapy; individual (psychodynamic therapy, dialectical behavior therapy, supportive therapy) case management, and crisis intervention (two hours/week, delivered by two supervisors); individual cognitive behavioral therapy (one hour/week, within a small group of interns); and family therapy (two hours/week, delivered in real-time, using a one-way mirror, and shared by the intern class, serving as consultants). Interns are also trained to conduct intake evaluations and treatment screenings.

CHILD TRACK

In the Child Outpatient Department, each intern carries a caseload of: one group (co-led with a staff member); one or two families; and several individual patients (including parent-infant dyads through the Parent-Infant Center), with a broad range of psychiatric and developmental problems, ages, demographic characteristics, ethnic, cultural and sexual identities, and life situations. The target population is children/adolescents, ages zero to eighteen, and their families. Interns receive individual supervision in each of the following areas: systems/group psychotherapy (one hour/week); individual psychotherapy (e.g., psychodynamic therapy, dialectical behavior therapy, cognitive behavior therapy, parent-infant therapy), crisis intervention, etc. (Two hours/week, delivered by two supervisors); and family therapy (one hour per week in group, sometimes using real-time, one-way mirror-assisted feedback) for a total of four hours per week. Interns may also conduct intake evaluations. Interns will have the opportunity to design individualized caseloads based on their specific areas of interest.

ASSESSMENT

In both Tracks, assessment is an important component of the Internship clinical experience. Each intern will administer, score, interpret, and compose a report for at least two comprehensive assessments. These assessments will make use of cognitive tests (i.e., WAIS-IV, WISC-V, WJ-IV), objective personality tests (e.g., MMPI, MCMI, MMPI-A), projective personality tests (e.g., Rorschach), structured psychiatric interviews (e.g., SCID), academic achievement, symptom rating scales, and neuropsychological screening tests, as needed. Interns receive intensive supervision on administration, interpretation, and report writing (i.e., approximately six hours/ assessment). In the Child Track, interns may focus their assessment experience in the Child and Family Institute Outpatient Psychiatry Department or in CARES. Please see Appendices for Assessment- and Neuropsychological Assessment-specific handbooks.

CONSULTATION AND INTER-PROFESSIONAL COLLABORATION

On all of the Rotations, as well as in the Adult and Child Outpatient Psychiatric Clinics, consultation is an aspect of the interns' clinical experience. In the process of implementing treatment plans, coordinating services for patients with complex problems, interns routinely consult with (psychiatric, social service, case management, medical and other) providers from community-based social service agencies, foster care agencies, hospitals, schools, universities, criminal justice agencies, and other facilities. The Department of Psychiatry and Behavioral Health Consultation-Liaison Services, for adults and children, are potential sites for interns to participate in consultation, as part of a team (with attending psychiatrists and psychiatry residents). Due to the already full-time workload of the interns, interns do not currently rotate into this service. However, optional opportunities, to join the Consultation-Liaison teams for a mini-rotation, are available -- should the intern and the Training Director or Associate Training Directors and the Directors of the adult and/or child Consultation-Liaison Services agree that they have sufficient time to do so.

The Program Structure is most clearly presented in the Table below. Major Program components are represented by undivided horizontal rows (e.g. such as 'Rotations'. We emphasize that: within every major component, activities are either shared (e.g. such as 'Year-Long Core Course') or parallel, while developmentally tailored, respectively, to work with Adults or Children/Adolescents, in the two Tracks. Details of Table items follow in the text.

PROGRAM STRUCTURE

Rotations	
<u>Adult</u> • Three 4-month rotations	<u>Child</u> • One-year placement at CARES and one 6-month rotation
Year-Long Outpatient Psychiatry Clinic Experience	
<u>Adult</u> • Individual psychotherapy • Group psychotherapy • Family therapy	<u>Child</u> • Individual psychotherapy • Group psychotherapy • Family therapy
Intensive Supervision	
<u>Adult</u> • Individual psychotherapy • Group psychotherapy • Family therapy	<u>Child</u> • Individual psychotherapy • Group psychotherapy • Family therapy
Assessment	
<u>Adult</u> • Two assessments over a 12-month period	<u>Child</u> • Two assessments over a 12-month period

Optional Mini-Rotations	
<ul style="list-style-type: none"> • Comprehensive Psychiatric Emergency Program (CPEP) • Consultation-Liaison Psychiatry Programs 	
Courses	
Orientation Series	
<u>Adult</u> <ul style="list-style-type: none"> * Two-week daily orientation in July 	<u>Child</u> <ul style="list-style-type: none"> * Six-week summer orientation
Year-Long Track-Specific Core Courses	
<u>Adult</u> <ul style="list-style-type: none"> • Twice-Weekly Adult-Tailored Core Course, covering Internship core competencies: 	<u>Child</u> <ul style="list-style-type: none"> • Once-Weekly Child/Adolescent-Tailored Core Course, covering Internship core competencies:
Year-Long Assessment Course	
<u>Adult</u> <ul style="list-style-type: none"> • Assessment lectures in CORE 	<u>Child</u> <ul style="list-style-type: none"> • Assessment lectures in CORE
Year-Long Multicultural Diversity Awareness Course	
<u>Adult</u> <ul style="list-style-type: none"> • Once-Monthly Multicultural Diversity Case Conference 	<u>Child</u> <ul style="list-style-type: none"> • Once-Monthly Multicultural Diversity Case Conference
Year-Long Family Seminar	
<ul style="list-style-type: none"> • Once-weekly Adult and Child interns combined seminar for 12 months 	
Year-Long Intern Process Group	
<u>Adult</u> <ul style="list-style-type: none"> • Once-weekly process group 	<u>Child</u> <ul style="list-style-type: none"> • Once-weekly process group
Year-Long, Weekly Department Of Psychiatry & Behavioral Health Grand Rounds	
<ul style="list-style-type: none"> • Early, mid- and end-of- year intern, supervisor, and training director evaluations • End of rotation evaluations • End of course evaluations • End-of-year Program Summary Evaluation 	

DIDACTICS

The MSSLW Internship Training Program contains two tracks within it:

- a.) The Adult track serves to train students interested in specializing in the treatment of adults (defined as roughly 18 and older by our program), and
- b.) The Child track serves to train students interested in specializing in the treatment of children (defined as prenatal to 17 by our program) and their families.

The schedule for clinical work and didactics for both of these tracks is detailed below. Within each track, trainees have morning and afternoon rotations and didactics seminars. Most of the rotations are track-specific with the exception of the CARES rotation which is offered in both tracks. Some of the didactic seminars described below are offered in our CORE training series and are attended by both child and adult interns. Other didactics are track-specific.

I. Orientation Seminars:

A.) New Beginnings: This is an orientation organized by Sinai System in which the medical center's fundamental aims and policies are reviewed. Both child and adult interns are required to attend this orientation on the first day of the internship.

B.) Internship Core Competence Orientation: This orientation is required of all interns (child and adult) on the second day of the training year. This orientation is run by the Director and the Associate Directors of Education and Training. During this orientation interns meet one another as well as key personnel in the training program. They also are given a copy of the Internship Handbook (uploaded to the portal associated with this Standard) which is reviewed at that time. Finally, interns divide up by track and meet with the relevant Director/Associate of Training to discuss their upcoming orientation week as well as their daily schedules for the summer months and going forward.

C.) Adult Specific Orientation: The orientation for the adult track is conducted during the first few weeks of the internship. This includes: a specific orientation to the Adult OPC (conducted by OPC faculty and attended by Psychiatry residents, Psychology Interns and Psychology Fellows) and formal didactics on: learning the charting software (EPIC), the Mental Status Examination, important charting requirements, how to manage the difficult outpatient, how to manage the violent inpatient, disposition and treatment planning, etc.

D.) Child Specific Orientation:

Orientation trainings and seminars for child interns occur over the first two months of internship. Orientations to the Child Outpatient Clinic as well as the CARES program are provided in the first two weeks of training. Orientations cover information regarding clinical practice, clinic policies, suicide/violence/risk assessment and intervention, management of agitation, safety planning, child maltreatment, ethics, legal issues and billing/documentation. Child interns also receive intensive didactics in Dialectical Behavior Therapy, Substance Use Monitoring/Treatment, Infant Mental Health and Milieu intervention during the summer.

II. Primary Clinical Rotations:

As previously noted, Adult interns select 3 from the below which they attend for 4 months each.

Child interns work in the CARES rotation (letter E below) each morning for the entire training year.

A.) Inpatient Rotation (Option for Adult Interns Only): Interns are assigned to one of two thirty-six bed inpatient units where they function as primary clinicians for their patients. Their responsibilities include intake evaluation, individual and group psychotherapy, psycho-diagnostic assessment, and participation as a team member in staff and unit community activities. Interns carry two individual inpatients, and co-lead one therapy group with a licensed staff member. On-site supervision is provided by the psychiatrist unit chiefs and chief psychiatry resident and off-site adjunctive supervision is provided by supervising psychologists. Interns attend and participate in daily morning rounds and also present at weekly inpatient case conferences during which the patients are also interviewed. Please see Appendices for this site-specific handbook.

B.) Psychiatric Recovery Center/ PRC- (Option for Adult Interns Only): This is an intensive outpatient program offering services designed to meet the needs of individuals with severe and persistent mental illness. A work and recovery model informs the treatment, and supports the goal of engagement in vocational, pre-vocational, or educational activity, either on-site or outside of the program. Psychology interns are an integral part of PRC's multidisciplinary team. Interns serve as primary therapists, conducting individual psychotherapy with four patients, leading several groups, and conducting weekly intakes for the both PRC and the Adult OPC. Interns may also conduct psycho-diagnostic assessment to help clarify diagnosis and level of functioning. The psychologist site director, as well as other psychologists on staff, provides supervision. Please see Appendices for this site-specific handbook.

C.) The Center for Intensive Treatment of Personality Disorders /CITPD- (Adult Interns Only): This is an intensive outpatient treatment program for adults who are in acute crisis. The majority of patients have affective illness and/or Axis II pathology. Treatment takes the form of various group and individual sessions aimed at helping patients resolve the acute crisis and make the transition back into the community. Dialectical Behavior Therapy (DBT) is a treatment focus as well as psychodynamic and process work. Interns carry two individual patients, co-lead several groups with licensed staff who are also their supervisors. They also conduct intakes. The psychologist site director, as well as other psychologists and licensed professionals on staff, provide supervision. All of this supervision is overseen and coordinated by the site director. This is the only required primary rotation at the present time so all adult interns rotate here for four months each. Please see Appendices for this site-specific handbook.

D.) The Addiction Institute of New York /AI- (Adult Interns Only): is a comprehensive substance abuse treatment center - which includes detoxification, intensive inpatient and outpatient rehabilitation, outpatient treatment programs, residential treatment, methadone, buprenorphine and other pharmacologic treatment, and a consultation service for medical/surgical inpatient units. The intern may be placed into specialty clinics of the outpatient treatment program (e.g., 'Crystal Clear' relapse prevention program for stimulant-using men who have sex with men, young adult program

for individuals with various types of substance use, DBT-informed groups for dually-diagnosed individuals with Axis II disorders, etc.) and/or in the intensive outpatient rehabilitation service. Interns co-lead several groups and provide as-needed individual counseling to group members. Interns may also participate in consultations with the medical/surgical services. The psychologist Assistant Clinical Director provide supervisions. Please see Appendices for this site-specific handbook.

E.) **The Comprehensive Adolescent Rehabilitation and Education Service /CARES:**

Year-long morning rotation for child interns/ Option of 4 month rotation for adult interns:

CARES is a safe and therapeutic school environment for New York City public high school students whose previous school performance has been limited by emotional and behavioral difficulties. The program provides educational and therapeutic components, including substance abuse treatment for students who use drugs or alcohol. CARES has 2 tracks: (1) The Adolescent Alternative Day Program (AADP) which is designed to help students whose school performance has been affected most by problems with social skills, anxiety, and/or mood changes; and (2) The Comprehensive Addiction Program for Adolescents (CAPA), which offers additional services for students seeking recovery from substance abuse. CAPA uses a harm-reduction model to help students reduce, and ultimately abstain from substance use. CARES provides multidisciplinary therapeutic services designed to address the specific problems that have interfered with each individual student's academic, social, and emotional success in the past. The CARES clinical staff works together as a team to make an individual treatment plan for each student, which will include: Individual Therapy (2x/week); Group Therapy (5 days/week); Family Therapy / Collateral Sessions (weekly/monthly); Psychopharmacology (monthly); Milieu Therapy (daily/as needed); Community Meetings; Complementary Services (ex: AA, NA, case management, waiver, linkages with community organizations). Throughout the Internship year, Child Track interns carry two individual treatment cases, one family therapy case, co-lead three groups and serve as milieu therapists. If adult interns chose this as their morning rotation, they treat one or two patients twice a week, co-lead one group, treat one family and participate in the milieu and in community meetings. The psychologist director and licensed staff psychologists provide supervision. Please see Appendices for this site-specific handbook.

II. Outpatient Clinical Rotations:

A.) **Adult Outpatient Clinic:** (Adult Interns Only): The AOPC is a high volume, psychiatric outpatient clinic serving a diverse population of individuals with wide-ranging socio-demographic, ethno-cultural, psychiatric and medical characteristics. The intern-trainee gains experience in providing psychotherapy in a range of modalities (e.g. CBT, DBT, MI, ACT, short and longer-term psychodynamic psychotherapy, group therapy and family therapy). He/she collaborates with a team of clinicians, including psychiatrists, nurse practitioners, psychologists, social workers, and psychiatric residents, to provide high-quality, evidence-based care. Interns typically carry 10-12 individual patients, co-lead one group and treat one family on an outpatient basis. In addition, they will conduct two psychological assessments per year. Interns have two outpatient supervisors, one family supervisor/consultant, one group supervisor and one assessment supervisor for their work in

the AOPC. They are also required to attend the AOPC interdisciplinary staff meeting every other week and the Psychosis Training Case Conference on the alternate weeks.

B.) Child Outpatient Department: (Child Interns Only) In the Child Outpatient Department, each intern carries a caseload of: one group (co-led with a staff member); one or two family cases; and 10-12 individual patients (including parent-infant dyads through the Parent-Infant Center), with a broad range of psychiatric and developmental problems, ages, demographic characteristics, ethnic, cultural and sexual identities, and life situations. The target population is children/adolescents, ages zero to eighteen, and their families. Interns receive individual supervision in each of the following areas: systems/group psychotherapy (one hour/week); individual psychotherapy (e.g., psychodynamic therapy, dialectical behavior therapy, cognitive behavior therapy, parent-infant therapy), crisis intervention, etc. (Two hours/week, delivered by two supervisors); and family therapy (one hour per week in group, sometimes using real-time, one-way mirror-assisted feedback) for a total of four hours per week. Interns may also conduct intake evaluations. Interns have the opportunity to design individualized caseloads based on their specific areas of interest.

C.) The Inpatient Child/Adolescent Psychiatry Unit (Babcock 5) - 7 weeks (Child Interns Only) The inpatient child and adolescent service rotation offers an opportunity to gain experience working therapeutically with severely disturbed youth and their families and to work side by side in a team approach with psychiatric nurses, art and rehabilitation therapists, medical students, social workers, psychiatric trainees, and attending psychiatrists. The unit services a diverse population of children aged 6 to 12 and adolescents aged 13 to 17. Approximately a third experience psychosis, a third experience severe impulsivity and hyperactivity, and a third mood disturbances; trauma is very common throughout. Interns participate in a 7-week rotation (3 hours/day, 4 days/week). Interns bring their specialist training to serve as an experienced leader in the implementation of individual therapy, group therapy, and management of a milieu behavioral program with close integration among the multidisciplinary staff. As a crucial member of the multidisciplinary rounds, interns gain the opportunity to learn basic principles of medication management and its surrounding nuanced effects on parent child dyad, dispositional planning considerations and strategies, and a broader understanding of the role of social service and family system work in the delivery of care to children and adolescents. Opportunities for individual supervision with the psychiatric attending faculty present an opportunity for greater immersion in care within a medical perspective to strengthen the psychology trainee's global development and to advance flexible care delivery and an understanding of the role of the acute inpatient unit in the contemporary mental health system.

III. On-Going Didactic Seminars and Workshops:

Note: Syllabi and reading materials (in list form as well as e-copy format) for each of the below courses are uploaded to the portal associated with this standard. E copies of all reading materials for each of the below courses are also uploaded to a training drive which is easily accessible to all trainees.

A.) Core Competency Seminar (50 minutes/ week): This weekly seminar is required of both child and adult interns and includes topics in the core competency syllabus which are central to important learning for both tracks. A complete schedule for this seminar is uploaded here. Modules in this

course include: (i.) several lectures on ethics, (ii.) a once monthly Diversity Seminar where interns present cases to the Chief Psychologist at MSSLW. These cases are discussed and considered through the lens of diversity and multicultural awareness, (iii.) A core testing module which includes an overview of: Projective tests, Neuropsychological tests, MMPI and NCMI, (iv.) a diversity workshop where trainees are encouraged to explore and discuss their own experiences with micro-aggressions vis-à-vis diversity and cultural differences, and (v.) specialized clinical topics such as: features of the psychodynamic approach (the frame, therapeutic rupture, enactment, etc...), addictions treatments (harm reduction), LGBTQ- sensitive treatments, trauma treatments, and models of supervision. See Core Competency Lectures Series.

B.) Family Seminar (75 minutes x2/month): (Child and Adult Interns together) This seminar is co-led by two licensed psychologists with specialized training in family and systems. One of these psychologists was trained at the widely-recognized Ackerman Institute in family systems and couples treatment. After a few weeks of family and systems theoretical training, interns are encouraged to present a family case which they are currently treating and then invited to bring that family to be treated for 1-2 sessions behind a one-way mirror. The treatment team (which includes the two co-leaders and the other interns) sits in the observation room and telephones in with their comments and suggestions. This is live-interactive supervision. Following this session, the team sits with the intern-therapist and discusses their impressions in light of the system theories previously taught. Interns attend this seminar twice a month.

C.) Process Group (75 minutes/week): This is a traditional process group required of both child and adult interns. This group is led by a licensed psychologist who is a member of the American Group Psychotherapy Association and who is trained in Tavistock's group methods. This group meets once a week for 60 minutes. The theory associated with this technique is reviewed in the first few weeks of the seminar. After that, the group functions with strict adherence to the model. By design, there is no contact between the Director/Associate Directors of Training and the leader of the process group except if a trainee asks to leave the group, is in danger or is posing a danger to someone else. (Trainees have asked to leave the group but no one has ever been in danger or posing a danger to another person.)

D.) Departmental Grand Rounds (75 minutes/week): Both child and adult interns are invited to attend the weekly departmental Grand Rounds. E. Didactics Specific to the Adult Track:

(i.) Year-long course in CBT/DBT and other evidence-based modalities (50 minutes/week): This team-taught weekly course aims to expose students to a series of diagnosis-specific evidence based treatment protocols. In the first half of the year, lecturers review these treatment manuals using slides, lectures, and other didactic approaches including workshops and role-plays. This half of the year reviews: Motivational Interviewing, CBT for Panic Disorder and GAD, CBT for OCD, CBT for Depression, CBT for Psychosis, CBT for Social Phobia, and several other diagnosis specific protocols. As the first semester of this course progresses, students are encouraged to bring in examples from cases they are treating as they are relevant to and help to explicate the protocols being taught. The second semester of this course is entitled "CBT in the Trenches- Applying the protocols in the real world". This half of the course is run a case conference where trainees present cases they are treating and are encouraged to think about the cases in light of the protocols taught earlier in the year. Protocols are written by researchers in "pure" settings where numerous diagnostic exclusions

are permitted. In our OPC, we treat real-life “imperfect” cases which require adaptation and modification of the protocol to fit the patient. Here we try to teach patient-driven treatment rather than simply applying the protocol to a patient who meets diagnostic criteria.

(ii.) Year-long course in psychodynamic therapies (50 minutes/week): This course is divided in to two semesters. During the first semester (July- mid December), themes and theories of different psychodynamic treatment approaches are reviewed and discussed. These therapeutic approaches are located in history and in the larger “over-arching map” of therapeutic approaches. The second semester of this course (mid-January-May) led by a trained analyst is run as a case conference for psychodynamic theory and thinking. Each student is expected to present audio-tapes from sessions with a selected patient. Interestingly, the presenter is not allowed to comment or discuss their perspective during these presentations. The seminar leader and other interns discuss the tapes and give feedback to the intern treating the case.

(iii.) AOPC Case Conference (60 minutes/x2 per month): This is a seminar where high-risk outpatients are presented and interviewed and treatment options are suggested and discussed. This seminar is run by the Adult Outpatient Clinic and is led by Dr. Marianne S. Goodman, an Assistant Professor of Psychiatry at The Mount Sinai School of Medicine. Dr. Goodman is involved in treatment research on borderline personality disorder and coordinates the medical student education program for the department of Psychiatry at the Bronx VA Medical Center. Her research focuses on Dialectical Behavioral Therapy treatment for borderline personality disorder and childhood trauma antecedents. Interns are invited to attend and to present in this seminar at least once in the course of their training year.

(iv.) Structured Interview for Prodromal Syndrome (SIPS) Training (2 days off-site): When trainees rotate through the PRC (above described), they are required to attend training in SIPS. This two day, off-site training teaches them to use the structured interview designed to rule out/in past and current psychosis, rule out/in psychosis risk syndromes and rate the current severity of the psychosis risk symptoms. After training, interns are expected to conduct one of these interviews during their time in the PRC rotation.

(iv.) Modular Course (50 minutes/week)– Other clinical topics of interest: In this year-long weekly course, a team of different faculty presents topics in which they are expert. These topics include: biofeedback, integrated treatment of character disorder, relational psychoanalysis, groups and systems, Lancaian theory and therapy, IPT, and using the termination in your treatment. In each case, the research and clinical evidence on which the treatment has been tested and developed is presented. Students are encouraged to question and challenge these methods and to ask questions informed by the patients they are treating. There is also a professional development component to this series in which former trainees come back to the hospital to talk about their current work and also speak about how to start a private practice.

F.) Didactics Specific to the Child Track:

(i.) Once weekly (60 minutes/week) Psychotherapy Course, a core course on evidence-based treatments for the major presenting problems of child and adolescent patients --internalizing and externalizing behaviors, anxiety and developmental trauma disorders, and substance use disorders. Topics include: working with caregivers; play therapy; treating externalizing disorders; treating

internalizing disorders; treating trauma; treating substance use disorders; group therapy; working with schools; transference/countertransference; and termination. Modules are designed to progress in depth and skill level as the year progresses, in an effort to parallel the interns' practical experiences with patients. This course is attended by Child Psychology Interns and Child Psychiatry 1st year Fellows which helps to facilitate their interdisciplinary collaboration.

(ii.) Once-weekly (60 minutes/week) Testing Course/Supervision related to the assessment of children and adolescents with possible learning and developmental disabilities. Interns participate in this course/supervision for approximately 2 months while they are completing psychological assessments.

INTERNSHIP ADMISSIONS, SUPPORT AND INITIAL PLACEMENT DATA

We are members of APPIC and fully abide by all of their policies. The program is listed each year in the APPIC Directory. To ensure accuracy, the information listed in the APPIC Directory is updated in a timely fashion. There are 5 funded internship positions in our APA-Accredited doctoral psychology internship program.

The Mount Sinai St. Luke's Internship Program is committed to a policy of nondiscrimination in our recruiting of all staff and trainees. Mount Sinai Health System is committed to providing an equal opportunity work environment. We comply with all laws, regulations and policies related to non-discrimination and fair employment practices in all of our personnel actions. We strongly encourage interested candidates from minority and/or disability backgrounds to apply.

Internship Program Qualifications

In accord with this philosophy, model and goals, interns with interests and experiences that match these elements are selected. In particular, the following are qualifications for the Internship Program

The following are qualifications for the Internship Program:

- Being a doctoral student in an APA-accredited Ph.D. or Psy.D. doctoral program in clinical, counseling or combined clinical-school psychology (both Adult and Child Tracks) or school psychology (Child Track)
- Having completed at least three years of doctoral study in such a program
- Having completed at least two years of supervised practicum and externship clinical experience with ethnoculturally diverse, poor, urban populations, comparable to those served by our hospital center (e.g. people with severe and persistent mental illness (Adult Track) , people with personality disorders (Adult Track), latency age and adolescent youth (Child Track), and others)
- Having worked in diverse clinical settings, comparable to those of our Internship (e.g. intensive outpatient treatment programs (both Adult and Child Tracks), inpatient units (Adult Track), community or hospital outpatient psychiatric clinics (both Adult and Child Tracks), foster care or social service agencies (Child Track), schools (child Track), and others)
- Having conducted individual and group therapy (both Adult and Child Tracks)

- Having administered, scored, interpreted and written reports on at least two comprehensive psychodiagnostic assessments

Internship Program Selection Process

All interested applicants should submit applications using the AAPI online application process. A 3-step intern selection process gives Internship Program Faculty the opportunity to thoroughly and collectively select intern applicants for ranking who are most appropriate for our Program. In particular:

- (1) Screening AAPI Online applications: The Training Director, Associate Training Directors, and Internship Program Faculty initially screen applications, using a standard application rating form, to determine their good standing at APA-accredited programs, and basic professional experience that would amply prepare them for our Internship. The form includes items covering: standing in APA-accredited Ph.D. or Psy.D. doctoral program in clinical, counseling or combined clinical-school psychology, or school psychology (Child Track); completion of at least three years of such doctoral study; clinical experience in a variety of settings; completion of sufficient number clinical assessment and intervention hours, with flexibility depending on other applicant experience and qualifications); clinical experience with severe pathology (Adult Track); clinical experience with latency age and adolescent youth (Child Track); clinical experience in intensive treatment modalities; clinical experience with a variety of populations, of different ethnicities, sexual orientations, ages, etc.); testing experience with complete batteries (i.e. a minimum of 2, but preferably 4); academic achievement (i.e. G.P.A. \geq 3.5); dissertation status (i.e. proposal approved or expected approval, by start of internship year); letters of reference stating superlative enthusiasm; and personal statements conveying (a) commitment to work with diverse urban populations and in diverse hospital-based settings, using multiple psychological approaches; (b) psychological mindedness; and (c) other characteristics. While the form is used as a guide, the Faculty application reviewer has flexibility, in considering the total cluster of applicant experiences and qualifications an applicant presents, in recommending whether or not a candidate should be interviewed. With these rating forms in hand, the Training Director and Associate Training Directors identify the list of applicants for interview. Because the work of the Adult and Child Tracks, respectively, in part, requires Track-specific expertise, the Associate Directors for each Track are responsible for generating this list.
- (2) Interviewing applicants: The Training Director, Associate Training Directors, and Internship Program Faculty participate in a shared interviewing process. During 4-hour time blocks: (1) The Training Director or Associate Training Directors orient between 6 and 12 applicants to the Internship Program; (2) 3 - 4 Faculty members separately, or in pairs, interview a given applicant; and (3) Led by the Training Director or Associate Training directors, all Faculty participating in the given time block have a consensus discussion – in which a collective rating of extent to which the applicant is a fit with our Internship Program is made. Interview ratings use a standard interview rating form, which is intended to tap impressions from both the applicant's interview and personal statements. Interviewing of applicants to both the Adult and Child Tracks is mainly conducted by Faculty with primary direct clinical or supervisory experience, respectively, within Adult Psychiatry or Child Psychiatry services, but also includes Faculty secondarily involved in the other Track.

- (3) Ranking applicants: With these collective ratings, of applicants who demonstrate excellent fit with our Program philosophy, goals, and training experiences, the Training Director and Associate Training Directors, generate a ranked list of applicants, for the Child and Track Tracks, respectively, to submit to the Match. This ranked list is discussed at special Faculty meetings – in which final adjustments are made in the ranked lists, if necessary. The final ranked list is discussed by the Training Director and Associate Training Directors, after which it is submitted to the Match by the Training Director.

The internship begins the first week in July and ends at the end of the following June.

Internship Program Tables - Updated: 8/30/2018

Internship Program Admissions

As previously stated, our internship program, housed at Mount Sinai St. Luke’s and West Hospitals is a comprehensive two track internship program. Five interns are accepted in to the adult track and four interns are accepted in to the child track. All internship applicants are expected to have completed a minimum of two full testing batteries and integrated reports before applying. Further, the program requires that applicants have a minimum number of hours of intervention and related supervision at the time of application.

Total Direct Contact Intervention Hours: 650 (preferred but minimum of 550)

Total Direct Contact Assessment Hours: 50

Financial and Other Benefit Support for Upcoming Training Year

Annual Salary for Full-Time Interns	\$31,200
Annual Salary for Half-Time Interns	N/A
<hr/>	
Program provides access to medical insurance for intern?	Yes
If access to medical insurance is provided:	
Trainee contribution to cost required?	Yes
Coverage of family member(s) available?	Yes
Coverage of legally married partner available?	Yes
Coverage of domestic partner available?	Yes
Hours of Annual Paid Personal Time Off (PTO and/or Vacation)	22 days
Hours of Annual Paid Sick Leave needed	7 days plus disability if

In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to interns/residents in excess of personal time off and sick leave?

Yes

Other Benefits: Dental and Vision insurance offered

Initial Post-Internship Positions 2015-2018

	PD	EP
Total # of interns who were in the 3 cohorts	36	
Total # of interns who did not seek employment because they returned to their doctoral program/are completing their doctoral degree	0	
	PD	EP
Community mental health center	1	
Federally qualified health center	1	
Independent primary care facility/clinic		
University counseling center		
Veterans Affairs medical center	1	
Military health center		
Academic health center	16	1
Other medical center or hospital		
Psychiatric hospital		
Academic university/department	3	
Community college or other teaching setting		
Independent research institution		
School district/system		

Independent practice setting	9	1
Not currently employed	3	
Change to another field		
Other		
Unknown		

Note: PD= Post-doctoral residency position; EP = Employed Position. Each individual represented in this table is counted only one time. For former trainees working in more than one setting, the setting that represents their primary position is selected.

SUPERVISION

The structure for supervision is different for each track. As such, each track is described separately below:

1. Adult Track:

Trainees in the adult track have a total of six supervisors. These supervisors are:

- a.) Two main OPC supervisors each of whom meets with the trainee for one hour a week to supervise them on OPC individual and family/couples cases. These supervisors will review audio or video records of the sessions the student brings. On rare occasions, the supervisor will meet directly with the patient and the trainee. This is usually if a specific issue or problem arises for which the supervisor would do best eye-balling the patient directly.
- b.) One OPC group supervisor who meets with them for one hour a week. Most group supervisors do not co-lead the group and will review audio or video recordings with the trainee. In the event that the supervisor and the trainee co-lead the group, the supervisor meets with the trainee for 30 minutes either immediately before or immediately after the group.
- c.) One morning rotation supervisor who meets with them at least once a week for the duration of time that they are the given rotation. Since trainees generally have three different morning rotations each four months in duration, this is typically for four months. On some rotations (e.g., CITPD and Addictions) supervisors will co-lead groups with the trainees.
- d.) One assessment/testing supervisor. This supervisor meets with the trainee several times a year in order to oversee their two assessments. Before the test case is assigned to a trainee, the referral is reviewed by the Director of Adult Assessment in conjunction with the Director of Training. Once it is determined to be an appropriate testing referral, the assessment supervisor and the trainee meet to review the referral form and to determine which tests would be appropriate. The supervisor can consult with the Director of Assessment at this point if help is needed. After this, the trainee is encouraged to meet with the assessment supervisor after each testing administration session. Once the testing is complete, trainees will meet with their supervisors for help in scoring the tests and creating the data based on which the report will be written. In cases where a trainee may have a relative deficit

in a given testing area (e.g., projectives) the supervisor might assign additional reading and meet with the trainee for a few adjunctive teaching sessions.

e.) In addition to the above formal supervisions, trainees also obtain supervisor from: (i.) the family consultation seminar in which cases are viewed through a one-way mirror, (ii.) from weekly staff meetings where cases are reviewed, (iii.) from didactic case seminars, (iv.) from unit wide case seminars/in-service trainings held on the inpatient unit and in the OPC, (v.) from on the spot, open-door supervisions or telephone consultations as needed. The availability of these supervisors on the unit ensure that students have access to supervision and consultation while they are providing clinical services.

Beyond what is listed above, unit chiefs or surrogates are present at all times on the various units. Most supervisors are also on site with open door policy. Supervisors meet weekly with the trainee and enter this meeting in to supervision logs so that frequency of supervision can be monitored. Supervisors also attest to each note written by trainees in the EPIC charting software system.

On rare occasions, interns will be supervised by licensed psychiatrists (eg on the inpatient unit) or co-lead groups with licensed social workers (e.g., the Addictions Unit and CITPD). When this occurs, the work is still reviewed during supervision with a licensed psychologist, and/or reviewed by the unit chief. All units and rotations save the inpatient unit are headed up by senior licensed psychologists. When rotating on the inpatient unit, trainees will meet separately with a licensed psychologist to review the work from the perspective of a psychologist.

2. Child Track

Trainees in the child track have a total of 5-7 supervisors. These supervisors are:

a.) Two main Child OPD supervisors, each of whom meets with the trainee for one hour a week to supervise them on OPC individual and family cases. These supervisors review audio or video records of the sessions the student brings. On rare occasions, the supervisor will meet directly with the patient and the trainee. This is usually if a specific issue or problem arises for which the supervisor would do best with direct patient contact.

b.) One to three group supervisors each of whom meet with the trainee for 30 minutes per week. Group supervisors provide feedback about group therapy interventions, process group dynamics and prepare to co-lead structured groups with trainees.

c.) One CARES rotation supervisor who meets with the intern at least once a week for the training year. CARES supervisors provide supervision for individual, family and milieu therapy at CARES.

d.) One assessment/testing supervisor. This supervisor meets with interns weekly during their 2.5 month testing rotations. The testing supervisor observes testing sessions conducted by the intern during that time and provides guidance and feedback.

In addition to the above formal supervisions, trainees from both tracks obtain supervisory input from: (i.) the family consultation seminar in which cases are viewed through a one-way mirror, (ii.) weekly staff meetings where cases are reviewed, (iii.) didactic case seminars, (iv.) unit-wide case seminars/in-service trainings held on the inpatient unit and in the OPC, and (v.) on the spot, open-door supervisions or telephone consultations as needed. The availability of these supervisors on the unit ensure that students have access to supervision and consultation while they are providing clinical services.

Beyond what is listed above, unit chiefs or surrogates are present at all times on the various units. Most supervisors are also on site with an open door policy. Supervisors meet weekly with the trainee and record this meeting in a supervision log so that frequency of supervision can be monitored. Supervisors also attest to each note written by trainees in the EPIC charting software system.

On rare occasions, interns will be supervised by licensed psychiatrists (e.g., on the inpatient unit) or co-lead groups with licensed social workers (e.g., the Addictions Unit and CITPD). When this occurs, the work is still reviewed during supervision with a licensed psychologist, and/or reviewed by the unit chief. All units and rotations, aside from the inpatient unit, are under the direction of a senior licensed psychologist. When rotating on the inpatient unit, trainees meet separately with a licensed psychologist to review their work.

GUIDELINES FOR SUPERVISION

Trainees receive individual, group and assessment supervision based on the Guidelines for Clinical Supervision in Health Psychology Services, approved by the APA Counsel of Representatives, 2014. These are the Board of Educational Affairs Task for on Supervision Guidelines (Members of the task force were: Carol Falender, Chair; Beth Doll; Michael Ellis; Rodney K. Goodyear; Nadine Kaslow (liaison from the APA Board of Directors); Stephen McCutcheon; Marie Miville; Celiane Rey-Casserly (liaison from BEA); and APA Staff: Catherine Grus and Jan-Sheri Morris.)

[Suggested Citation: American Psychological Association. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from <http://apa.org/about/policy/guidelines-supervision.pdf>]

Preface

These guidelines for supervision of students in health service psychology education and training programs. The goal was to capture optimal performance expectations for psychologists who supervise. It is based on the premises that supervisors a) strive to achieve competence in the provision of supervision and b) employ a competency-based, meta-theoretical approach² to the supervision process. (A competency-based approach is meta-theoretical and refers to working within any theoretical or practice modality, systematically considering the growth of specific competencies in the development of competence.)

The *Guidelines on Supervision* were developed as a resource to inform education and training regarding the implementation of competency-based supervision. The *Guidelines on Supervision* build on the robust literatures on competency-based education and clinical supervision. They are organized around seven domains: supervisor competence; diversity; relationships; professionalism; assessment/evaluation/feedback; problems of professional competence, and ethical, legal, and

regulatory considerations. The *Guidelines on Supervision* represent the collective effort of a task force convened by the APA Board of Educational Affairs (BEA).

Guidelines for Clinical Supervision in Health Service Psychology

Executive Summary

The purpose of the Guidelines for Clinical Supervision in Health Service Psychology (hereafter referred to as Guidelines on Supervision) is to delineate essential practices in the provision of clinical supervision. The overarching goal of these Guidelines on Supervision is to promote the provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence ensuring the protection of clients/patients and the public. These Guidelines on Supervision are intended to be aspirational in nature to guide psychologists proactively towards enhancing supervision practice. The term Guidelines on Supervision, as used in this document, is consistent with the provisions of the American Psychological Association (APA) policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004), as passed by the APA Council of Representatives.

An assumption underlying all supervision is that the supervisor is competent—both as a professional psychologist and as a clinical supervisor (Fouad et al., 2009). Supervision is for assessment, treatment, and other activities of the health service psychologist; and it occurs across varied settings. Ironically, however, minimal attention has been given to defining, assessing, or evaluating supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013) or to determining requisite training for clinical supervision. The supervisor is responsible for ensuring the protection of the public, and this duty cannot be achieved without supervisor competence. This requires developing the knowledge, skills, and attitudes in the provision of supervision, and receiving training specific to clinical supervision (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). Further, education and training in health service psychology increasingly employs a competency-based approach to the definition, assessment, and evaluation of student learning outcomes. Both the competence of supervisors and the application of competency-based approach to supervision can be enhanced by developing guidelines that assist supervisors in the provision of high quality supervision.

The Guidelines on Supervision are the product of a task force convened by the APA Board of Educational Affairs. Members of the task force were selected for their expertise in the area of supervision. The majority of their work was conducted through conference calls and electronic mail with one face-to-face meeting; and the task force adhered to a tight timeline in recognition of the considerable need for such a document.

The Guidelines on Supervision are predicated on a number of common assumptions and agreed upon definitions. Although an extensive list of definitions appears in Appendix A to this document, three key definitions are provided below:

Health service psychologist. “Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic

intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level” (APA, 1996).

The Guidelines on Supervision focus on supervision for health service psychologists. A health service psychologist was defined by APA policy in 1996 and reaffirmed in the 2011 revision of the APA Model Act for State Licensure of Psychologists (APA, 2011c). Members of the task force agreed that a clear and delimited scope for the Guidelines on Supervision was important to promote understanding and use of this document. The term health service psychology (HSP) is preferred as it is narrower than professional psychology, a designation that includes the specialty of industrial-organizational psychology, which was not addressed by the task force. Health service psychology is inclusive of the specialties of clinical, counseling, and school psychology.

Supervision is a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. Henceforth, supervision refers to clinical supervision and subsumes supervision conducted by all health service psychologists across the specialties of clinical, counseling, and school psychology.

Competency-based supervision is a meta-theoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske, 2007). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision.

The Guidelines on Supervision are organized around seven domains:

Domain A: Supervisor Competence Domain B: Diversity Domain C: Supervisory Relationship
Domain D: Professionalism Domain E: Assessment/ Evaluation/ Feedback Domain F: Problems of Professional Competence Domain G: Ethical, Legal, and Regulatory Considerations

Within each of these seven domains, guidelines for supervision are articulated with a supporting rationale informed by the empirical and theoretical literature. Although this framework is useful to present the Guidelines on Supervision, there is considerable conceptual and practical overlap among these domains. Consideration was given to the utility and implementation of the Guidelines on Supervision as well as to minimizing redundancy when making decisions about the best domain for a specific guideline.

Introduction

Statement of Need and Context for the Guidelines on Supervision

A primary goal of education and training programs in health service psychology is to prepare psychologists who are competent to engage in provision of psychological services and professional practice. Supervision is thus a cornerstone in the preparation of health service psychologists (Falender et al., 2004). There is a tremendous amount of conceptual, theoretical, and research literature pertaining to supervision, but prior to the development of these Guidelines on Supervision, there has been no set of consensually agreed upon guidelines adopted as association policy to inform the practice of high quality supervision for health service psychology.

Although supervisor competency is assumed, little attention has been focused on the definition, assessment, or evaluation of supervisor competence (Bernard & Goodyear, 2014; Falender & Shafranske, 2013). This has diminished the perceived necessity for training in supervision. As Kitchener (2000) concluded, it has been much easier to identify the absence of competence than to define it. Articulating practices consistent with competent supervision ultimately facilitates the provision of quality services by supervisees and minimizes potential harm to supervisees and clients (Ellis et al., 2014).

Competence entails performing one's professional role within the standards of practice and includes the ability to identify when one is not performing adequately. An essential aspect of competence is metacompetence, or the ability to know what one does not know and to selfmonitor reflectively one's ongoing performance (Falender & Shafranske, 2007; Hatcher & Lassiter, 2007; APA, 2010, 2.01). Professional negligence is the failure of competence and is legally actionable: a failure of competence is practicing below a reasonable standard of care for supervision (Falender & Shafranske, 2014; Saccuzzo, 2002).

While clinical supervision has been recognized as a distinct activity in the literature, its recognition as a core competency domain for psychologists has been a long time coming (Bernard & Goodyear, 1992; Hess, 2011). Since the profession's adoption of supervision as a distinct professional competence (Fouad et al., 2009; Kaslow et al., 2004), a definition of supervision has emerged and encompasses the knowledge, skills, and values/attitudes specific to the practice of supervision (Falender et al., 2004; Falender & Shafranske, 2004, 2007; Fouad et al., 2009). This recognition of supervision as a distinct competency has evolved in the context of an overall focus on competency-based education and training in health service psychology that has gained momentum over the past decade (Fouad & Grus, 2014). The movement is consistent with the national dialogue about the responsibility of education and training programs to be accountable for ensuring quality education and training that leads to expected student learning outcomes (New Leadership Alliance for Student Learning and Accountability, 2012).

Supervisory competency includes valuing supervision as a distinct professional competency and valuing specific training in clinical supervision (Falender, Burnes, & Ellis, 2013; Falender, Ellis, & Burnes, 2013; Reiser & Milne, 2012). However, the recognition that training in supervision is necessary has also been slow to occur (Rings, Genuchi, Hall, Angelo,

& Cornish, 2009). A preliminary framework for supervisor competence was produced by the 2002 Competencies Conference (Falender et al., 2004), received confirmatory support from doctoral internship directors (Rings et al., 2009), and serves as a basis for this framework. To be a competent

supervisor, an individual possesses and maintains knowledge, skills, and values/attitudes that comprise the distinct professional competency of clinical supervision as well as general competence in the areas of clinical practice supervised and in consideration of the cultural contexts.

Supervision that applies a competency-based approach entails the creation of an explicit framework and method to initiate, develop, implement, and evaluate the process and outcomes of supervision. A competency-based approach is predicated on supervisors having the knowledge, skills, and attitudes regarding the provision of quality supervision and professional psychology models, theories, practices. In addition, supervisors have knowledge, skills and values with respect to multiculturalism and diversity, legal and ethical parameters; and management of supervisees who do not meet criteria for performance. Supervisors also attain knowledge and skills in theories and processes for group, individual, and distance supervision. Implicit in the concept of competence is an awareness of and attention to one's interpersonal functioning and professionalism and valuing individual and cultural diversity (Kaslow et al., 2007). The competency-based approach is being adopted in multiple specialties (e.g., Stucky, Bush, & Donders, 2010), psychotherapy theoretical approaches (e.g., Farber, 2010; Farber & Kaslow, 2010; Sarnat, 2010), and internationally (e.g., Psychology Board of Australia, 2013).

A logical next step to build upon the identified elements of competence in supervision is to develop and approve guidelines that promote the provision of competent supervision. Other organizations have published guidelines on supervision that have informed the development of these Guidelines on Supervision. Specifically, the following regulatory boards and psychological associations have promulgated guidelines related to supervision.

- The Association for Counselor Education and Supervision (ACES), a division of the American Counseling Association developed supervision guidelines for counselor education (Borders et al., 2011). The ACES guidelines on supervision are organized around 12 domains.
- 3 • The American Association of Marriage and Family Therapy developed a formal approval process for supervisors with nine learning objectives that candidates must demonstrate (American Association of Marriage and Family Therapy, 2007).
- 4 3 ACES categories are: initiating supervision, goal setting, giving feedback, conducting supervision, the supervisory relationship, diversity and advocacy considerations, ethical considerations, documentation, evaluation, supervision format, the supervisor, and supervisor preparation.
- 4 AAMFT categories include: knowledge of supervision models, ability to delineate one's own model of supervision, ability to foster relationships with the supervisee and the client, assess relationship problems, conduct supervision using various modalities, able to act on considerations within the supervisory relationship, attentive to issues of diversity, knowledge of ethical and legal issues related to supervision, and AAMFT supervisor procedural knowledge.

- The National Association for School Psychologists addresses supervision as part of a more comprehensive document on the provision of integrated and comprehensive school psychological services (National Association for School Psychologists, 2010).
- The Psychology Board of Australia's Guidelines for supervisors and supervisor training providers consists of a document that focuses on competency-based supervision (Psychology Board of Australia, 2013).
- The Australian Psychological Society Guidelines on Supervision specifically addresses the supervision contract, ethical issues, and supervision contexts (Australian Psychological Society, 2003).
- The New

Zealand Psychologists Board's Best-practices guidelines for supervision provides recommendations about a variety of aspects of supervision including the process and functions of supervision, supervisor competencies, the supervision relationship, and cultural issues (New Zealand Psychologists Board, 2007). • The British Psychological Society, Committee on Training in Clinical Psychology has guidelines for clinical supervision within their criteria for the accreditation of postgraduate training programs in clinical psychology (British Psychological Society, Committee on Training in Clinical Psychology, 2008). • The Association of State and Provincial Psychology Boards (ASPPB) is currently revising their supervisions guidelines (Steve DeMers, personal communication, 2013a). • The California Board of Psychology has published a document on supervision best practices (California Board of Psychology, 2010). • The College of Psychologists of Ontario, Canada has a Supervision Resource Manual (2nd edition) (College of Psychologists of Ontario, Canada, 2009). • The Canadian Psychological Association developed the Ethical guidelines for supervision in psychology: Teaching, research, practice, and administration (Canadian Psychological Association, 2009) and a Resource guide for psychologists: Ethical supervision in teaching, research, practice, and administration (Pettifor et al., 2010). Four principles frame the guidelines (from the CPA Code of Ethics, 2000): respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society. • The Association of Social Work Boards has developed guidelines on supervision for both educators and regulators using a competency framework identifying six domains of competence (Association of Social Work Boards, 2009). • The National Association of Social Workers and the Association of Social Work Boards recently released a document on best practices for supervision (National Association of Social Workers and the Association of Social Work Boards, 2013), articulating five standards: context in supervision, conduct of supervision, legal and regulatory issues, ethical issues, and technology.

Scope of Applicability

These Guidelines on Supervision are meant to inform the practice of clinical supervision with supervisees in areas of health service psychology and training. They apply to the full range of supervised service delivery including assessment, intervention, and consultation and across all aspects of professional functioning. The Guidelines on Supervision are predicated on a number of pre-existing policies, fundamental assumptions, and definitions:

Supervision can occur in a variety of contexts: supervision of service delivery by supervisees, administrative supervision, supervision of research activities conducted by supervisees, and supervision of individuals mandated by regulatory entities related to disciplinary actions. This document addresses supervision of clinical services provided by individuals in health service psychology education and training programs and applies to supervision of practicum experiences, internships, and postdoctoral training.

Interprofessional education is a valuable training activity and supervisees should have opportunities to learn from and with professionals other than a psychologist. Recent guidelines for Interprofessional Collaborative Practice (2011) were endorsed by APA (Interprofessional Education Collaborative, 2011). However, this supervision guidelines document refers exclusively to supervision provided by psychologists to supervisees in health service psychology.

Supervisors are committed to upholding the APA Ethical Principles of Psychologists and Code of Conduct (2010) and adhering to state and federal statutes regulating psychologist and psychological practice. Supervisors strive to adhere to relevant APA general practice guidelines including but not limited to the Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients, Guidelines for Assessment of and Intervention with Persons with Disabilities, Guidelines for Psychological Practice with Girls and Women, Guidelines for Psychological Practice with Older Adults, and the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (APA, 2011a, 2011b, 2007a, 2004a, 2003).

Supervisors are expected to comply with relevant education and training standards such as those promulgated through the APA Commission on Accreditation (APA, 2009) as well as other relevant guidelines, e.g., American Psychological Association Guidelines for the Practice of Telepsychology (APA, 2013a), Guidelines for Psychological Practice in Health Care Delivery Systems (APA, 2013b), and Record Keeping Guidelines (APA, 2007b).

Assumptions of the Guidelines on Supervision

The development of these Guidelines on Supervision is predicated on a number of assumptions. These assumptions were agreed upon by the members of the task force as foundational to the provision of clinical supervision and are reflected in the guidelines delineated in this document. Specifically, supervision:

- is a distinct professional competency that requires formal education and training
- prioritizes the care of the client/patient and the protection of the public
- focuses on the acquisition of competence by and the professional development of the supervisee
- requires supervisor competence in the foundational and functional competency domains being supervised
- is anchored in the current evidence base related to supervision and the competencies being supervised
- occurs within a respectful and collaborative supervisory relationship, that includes facilitative and evaluative components and which is established, maintained, and repaired as necessary
- entails responsibilities on the part of the supervisor and supervisee
- intentionally infuses and integrates the dimensions of diversity in all aspects of professional practice
- is influenced by both professional and personal factors including values, attitudes, beliefs, and interpersonal biases
- is conducted in adherence to ethical and legal standards
- uses a developmental and strength-based approach
- requires reflective practice and self-assessment by the supervisor and supervisee
- incorporates bi-directional feedback between the supervisor and supervisee
- includes evaluation of the acquisition of expected competencies by the supervisee
- serves a gatekeeping function for the profession
- is distinct from consultation, personal psychotherapy, and mentoring⁵

Use of the Term Guidelines

The term guidelines generally refers to pronouncements, statements, or declarations that recommend or suggest specific professional behaviors, endeavors, or conduct for psychologists. In this spirit, they are aspirational in intent. They are not intended to be mandatory or exhaustive and may not be applicable to every situation, nor are they intended to take precedence over the judgment of supervisors or others who are responsible for education and training programs. Education and

training guidelines may be written as an advisory set of procedures related to curriculum development, pedagogy, or assessment; as interpretive commentary or instruction on education policy or standards; as a set of guiding principles about teaching and learning or

5 Supervision is distinguished from these other professional activities by 1) professional responsibility and liability, 2) the purpose of the activity, 3) the relative power of the parties involved, and 4) the presence or absence of evaluation. In consultation, the consultant does not evaluate the referring provider, does not bear case responsibility, and the consultee is not required to implement the input of consultation. Supervision is distinguished from personal psychotherapy of the supervisee by maintaining the focus of inquiry on the client/patient, supervisee reactions to the client/patient, and/or the supervision process related to the client/patient (Bernard & Goodyear, 2014; Falender & Shafranske, 2004). Mentoring is distinguished from supervision by an absence of evaluation or power differential, and by the mentor's advocacy for the protege's professional development and welfare (Johnson & Huwe, 2002; Kaslow & Mascaro, 2007). Program development; or as suggested goals and objectives of learning. These Guidelines on Supervision are intended as suggestions or recommendations for psychologists providing supervision of students in education and training programs in health service psychology. As used in this document, the term guidelines is consistent with the provisions of the APA policy on Developing and Evaluating Standards and Guidelines Related to Education and Training in Psychology (Section I C[1]) (APA, 2004b), as passed by the APA Council of Representatives.

Process of Developing the Guidelines on Supervision

The Guidelines on Supervision were prepared by a task force convened by the APA Board of Educational Affairs in March of 2012. The task force was charged to:

“develop education and training guidelines for promising practices in (1) supervision encompassing the range of requisite supervisor {supervision} competencies; (2) adoption of a competency-based approach to supervision mindful of the developmental trajectory of the supervisee {of the process}.”

The task force met via conference call approximately once a month from late summer 2012 to early spring 2013. One face-to-face meeting of the task force occurred May 31-June 2, 2013 at which previously prepared drafts of the Guidelines on Supervision were discussed and revised. Following the meeting, the task force continued to refine the Guidelines on Supervision via electronic mail.

Purpose of these Guidelines on Supervision

The Guidelines on Supervision have the potential for broad impact on the profession by delineating practices relevant to quality supervision. Specifically, the Guidelines on Supervision are intended to have the following impacts:

- For supervisors, the Guidelines on Supervision provide a framework to inform the development of supervisors and to guide self-assessment regarding professional development needs.
- For supervisees, the Guidelines on Supervision promote the delivery of competency-based supervision with the goal of supervisee competency development.

- A goal of the Guidelines on Supervision is to provide assurance to regulators that supervision of students in education and training programs in health service psychology is provided with and places value on quality.

Implementation Steps

BEA will serve as the APA entity responsible for oversight of the implementation process. Implementation and dissemination of the Guidelines on Supervision will occur through:

- Distribution to and possible endorsement by the member organizations represented on the Council of Chairs of Training Councils, including the doctoral training councils and the Association of Psychology Postdoctoral and Internship Centers
- Presentations at the annual meetings of the APA and training council meetings.
- Submission to a peer-reviewed psychology journal for publication of a manuscript describing the Guidelines on Supervision.
- Submission to the APA Commission on Accreditation for consideration as a resource document in program reviews for accreditation.
- Development of continuing education programs targeted to health service psychologists who may not have had formal training in supervision.

Feedback

The Guidelines on Supervision is a “living document.” Accordingly, APA has established a systematic plan for periodically reviewing and revising such documents to reflect developments in the discipline and the education and training process. Formal reviews will occur every ten years, which is consistent with APA Association Rule 30-8.3 requiring cyclical review of approved standards and guidelines within periods not to exceed 10 years. Comments and suggestions are welcomed at any time.

Feedback on the Guidelines on Supervision may be sent to: edmail@apa.org.

Guidelines for Clinical Supervision in Health Service Psychology

The Guidelines on Supervision are organized around seven domains:

Domain A: Supervisor Competence Domain B: Diversity Domain C: Supervisory Relationship
Domain D: Professionalism Domain E: Assessment/ Evaluation/ Feedback Domain F: Problems of Professional Competence Domain G: Ethical, Legal, and Regulatory Considerations

These domains are drawn from a review of the literature on supervision as well as competency-based education and training. The domains and their associated Guidelines are interdependent and while some overlap exists among them it is important that they are considered in their entirety.

Domain A: Supervisor Competence

Supervision is a distinct professional practice with knowledge, skills, and attitudes, that supervisors require specific training to attain (Falender, Burnes, & Ellis; 2013; Falender, Ellis, & Burnes, 2013; Bernard & Goodyear, 2014; Reiser & Milne, 2012). The supervisor serves as role model for the

supervisee, fulfills the highest duty of protecting the public, and is a gatekeeper for the profession ensuring that supervisees meet competence standards in order to advance to the next level or to licensure.

1. Supervisors strive to be competent in the psychological services provided to clients/patients by supervisees under their supervision and when supervising in areas in which they are less familiar they take reasonable steps to ensure the competence of their work and to protect others from harm.

Supervisors possess up-to-date knowledge and skills regarding the areas being supervised (e.g., psychotherapy, research, assessment), psychological theories, diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and individual differences and intersections of these with diversity dimensions. Supervisors also have knowledge of the clinical specialty areas in which supervision is being provided and of requirements and procedures to be taken when supervising in an area in which expertise has not been established (Barnett et al., 2007; Goodyear & Rodolfa, 2012; APA, 2010, 2.01, 2.03). Supervisors are knowledgeable of the context of supervision including its immediate system and expectations, and the sociopolitical context. Supervisors are knowledgeable too about emergent events in the setting or context that impact the client(s)/patient(s) (Falender et al., 2004).

2. Supervisors seek to attain and maintain competence in the practice of supervision through formal education and training.

Competence entails demonstrated evidence-based practice as well as in the various modalities (e.g., family, group and individual), theories, and general knowledge, skills, and attitudes and research support of competency-based supervision. Supervisors obtain requisite training in knowledge, skills, and attitudes of clinical supervision (Newman, 2013; Watkins, 2012). Supervisors are skilled and knowledgeable in competency-based models, in developing and managing the supervisory relationship/alliance (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Ladany, Mori, & Mehr, 2013), and in enhancing the supervisee's clinical skills (Milne, 2009). The formal education and training should include instruction in didactic seminars, continuing education, or supervised supervision. At a minimum, education and training in supervision should include: models and theories of supervision; modalities; relationship formation, maintenance, rupture and repair; diversity and multiculturalism; feedback, evaluation; management of supervisee's emotional reactivity and interpersonal behavior; reflective practice; application of ethical and legal standards; decision making regarding gatekeeping; and considerations of developmental level of the trainee (Bernard & Goodyear, 2014; Falender & Shafranske, 2012; Newman, 2013). The supervision reflects practices informed by competency- and evidence-based practice to enhance accountability (Milne & Reiser, 2012; Reese et al., 2009; Stoltenberg & Pace, 2008; Watkins, 2011; Watkins, 2012; Worthen & Lambert, 2007). Assessment entails use of outcome measures and ratings from multiple supervisors (e.g., Reese et al., 2009, Watkins, 2011; Worthen & Lambert, 2007). Assessment strategies include both formative and summative evaluation and procedures for competence assessment.

3. Supervisors endeavor to coordinate with other professionals responsible for the supervisee's education and training to ensure communication and coordination of goals and expectations.

Coordination can assist supervisees in managing these multiple roles and responsibilities as well as supervisory expectations. Coordination is especially important to seek when a supervisee is exhibiting performance problems, when the supervisory relationship is under stress, or when the supervisor seeks another perspective (Thomas, 2010).

4. Supervisors strive for diversity competence across populations and settings (as defined in APA, 2003).

Diversity competence is an inseparable and essential component of supervision competence that involves relevant knowledge, skills, and values/attitudes (for more information, see Domain B: Diversity).

5. Supervisors using technology in supervision (including distance supervision), or when supervising care that incorporates technology, strive to be competent regarding its use.

Supervisors ensure that policies and procedures are in place for ethical practice of telepsychology, social media, and digital communications between any combination of client/patient, supervisee, and supervisor (APA, 2013b; Fitzgerald, Hunter, Hadjistavropoulos, & Koocher, 2010). Considerations should include services appropriate for distance supervision, confidentiality, and security.

Supervisors are knowledgeable about relevant laws specific to technology and supervision, and technology and practice. Supervisors model ethical practice, ethical decision-making, and professionalism, and engage in thoughtful dialogues with supervisees regarding use of social networking and internet searches of clients/patients and supervisees (Clinton, Silverman, & Brendel, 2010; Myers, Endres, Ruddy, & Zelikovsky, 2012).

Domain B: Diversity

Diversity competence is an inseparable and essential component of supervision competence. It refers to developing competencies for working with diversity issues and diverse individuals, including those from one's own background. More commonly, these competencies refer to working with others from backgrounds different than one's own but includes the complexity of understanding and factoring in the multiple identities of each individual: client(s), supervisee, supervisor and differing worldviews. Competent supervision attends to a broad range of diversity dimensions (e.g., age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status), and includes sensitivity to diversity of supervisees, clients/patients, and the supervisor (APA, 2003, 2004a, 2007a, 2010 (2.03); 2011a, 2011b). Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege and the impact of those on the supervisory power differential, relationship, and on client/patient and supervisee interactions and supervision interactions.

1. Supervisors strive to develop and maintain self-awareness regarding their diversity competence, which includes attitudes, knowledge, and skills.

Supervisors understand that they serve as important role models regarding openness to self-exploration, understanding of one's own biases, and willingness to pursue education or consultation

when indicated. Supervisors also are important role models regarding their diversity knowledge, skills and, attitudes. Supervisors' ability to self-reflect, revise and update knowledge and advance their skills in diversity serve as important lessons for supervisees. Modeling these competencies helps to establish a safe environment in which to address diversity dimensions within supervision as well as in the larger professional setting.

2. Supervisors planfully strive to enhance their diversity competence to establish a respectful supervisory relationship and to facilitate the diversity competence of their supervisees.

Supervisors consider infusion of diversity competence in supervision as an ethical imperative and respect the human dignity of their supervisees and the clients/patients with whom the supervisee works (APA, 2010; Bernard & Goodyear, 2014; Falender, Shafranske, & Falicov, 2014). Supervisors play a significant role in developing the diversity competencies of their supervisees. Research finds that diversity competence among supervisors can lag behind that of their supervisees (Miville, Rosa, & Constantine, 2005). Fortunately, diversity competence can be directly and constructively addressed by supervisors, who in turn can facilitate the diversity competence of their supervisees. Moreover, all supervision can be viewed as multicultural in the same manner that all therapy is multicultural (Pederson, 1990). Adopting such a framework strengthens the supervisory relationship, enhances supervisor competence, and promotes the diversity competencies of both supervisors and supervisees (Andrews, Kuemmel, Williams, Pilarski, Dunn, & Lund, 2013; Dressel, Consoli, Kim, on, 2007; Snowman, McCown, & Biehler, 2012). Viewing diversity as normative, rather than as an exception, aids supervisors in being sensitive to important similarities and differences between themselves and their supervisees that may affect the supervisory relationship.

3. Supervisors recognize the value of and pursue ongoing training in diversity competence as part of their professional development and life-long learning.

In order to ensure diversity competence sufficient to provide culturally sensitive supervision, supervisors seek to continue to develop their own knowledge, skills, and attitudes, particularly in diversity domains that are most commonly relevant to their clinical supervision. At a minimum, supervisors should have attained formal training in diversity through their own doctoral training program or continuing professional development workshops, programs, and independent study, should be familiar with APA guidelines addressing diversity (APA, 2003, 2004a, 2007a, 2011a, 2011b), and should pursue continuing education to maintain current competence and build knowledge in emerging areas (APA, 2010, 2.03).

4. Supervisors aim to be knowledgeable about the effects of bias, prejudice, and stereotyping. When possible, supervisors model client/patient advocacy and model promoting change in organizations and communities in the best interest of their clients/patients.

Supervision occurs within the context of diversity and social and political systems. Of special importance is the impact of bias, prejudice and stereotyping, both positive and negative, on therapeutic and supervisory relationships within these systems. Supervisors promote the supervisee's competence by modeling advocacy for human rights and intervention with institutions and systems (Burnes & Singh, 2010).

5. Supervisors aspire to be familiar with the scholarly literature concerning diversity competence in supervision and training. Supervisors strive to be familiar with promising practices for navigating conflicts among personal and professional values in the interest of protecting the public.

Considerable scholarship has been published on supervision and diversity (e.g., Bernard & Goodyear, 2014; Falender, Burns, & Ellis, 2013; Miville et al., 2009). Resources include competency-based training models for integrating diversity dispositions of supervisors and supervisees (Miville et al., 2009), and the duty of supervisors to assist supervisees in navigating inevitable tensions between personal and professional values in providing competent client/patient care (e.g., Behnke, 2012; Bienske & Mintz, 2012; Forrest, 2012; Mintz, Jackson, Neville, Illfelder-Kaye, Winterowd, & Loewy, 2009; Winterowd, Adams, Miville, & Mintz, 2009).

Domain C: Supervisory Relationship

The quality of the supervisory relationship is essential to effective clinical supervision (e.g., Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Holloway, 1995; O'Donovan, Halford, & Walters, 2011). Quality of the supervision relationship is associated with more effective evaluation (Lehrman-Waterman & Ladany, 2001), satisfaction with supervision (Ladany, Ellis, & Friedlander, 1999), and supervisee self-disclosure of personal and professional reactions including reactivity and countertransference (Falender & Shafranske, 2004; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). The power differential is a central factor in the supervisory relationship and the supervisor bears responsibility for managing, collaborating, and discussing power within the relationship (Porter & Vasquez, 1997).

1. Supervisors value and seek to create and maintain a collaborative relationship that promotes the supervisees' competence.

Supervisors initiate collaborative discussion of the expectations, goals, and tasks of supervision. By initiating this discussion, they establish a working relationship that values the dignity of others, responsible caring, honesty, transparency, engagement, attentiveness, and responsiveness, as well as humility, flexibility, and professionalism (Ellis, Ring, Hanus, & Berger, 2013). In discussing the supervisory relationship, the supervisor should: (1) initiate discussions about differences, including diversity, values, beliefs, biases, and characteristic interpersonal styles that may affect the supervisory relationship and process; (2) discuss inherent power differences and supervisor responsibility to manage such differences wisely; and (3) take responsibility to establish relationship conditions that promote trust, reliability, predictability, competence, perceived expertise, and developmentally-appropriate challenge.

2. Supervisors seek to specify the responsibilities and expectations of both parties in the supervisory relationship. Supervisors identify expected program competencies and performance standards, and assist the supervisee to formulate individual learning goals.

The supervisor is encouraged to explicitly discuss with the supervisee aspects of the supervision process such as: program goals, individual learning goals, roles and responsibilities, description of structure of supervision, supervision activities, performance review and evaluation, and limits of

supervision confidentiality. The supervisor also provides clarity about duties including that the primary duty of supervisor is to the client/patient, and secondarily to competence development of the supervisee. (The supervision contract is discussed further in the Legal and Ethical Section.)

3. Supervisors aspire to review regularly the progress of the supervisee and the effectiveness of the supervisory relationship and address issues that arise.

As the supervisory relationship and the supervisee's learning needs evolve over time, the supervisor should work collaboratively with the supervisee to revise the supervision goals and tasks. When disruptions occur in the supervisory relationship, supervisors seek to address and resolve the impasses and disruptions openly, honestly, and in the best interests of client/patient welfare and the supervisee's development (Safran, Muran, Stevens, & Rothman, 2008).

Domain D: Professionalism

Professionalism goes hand in hand with a profession's social responsibility (see Hodges et al., 2011; Vasquez & Bingham, 2012). The "professionalism covenant" puts the needs and welfare of the people they serve at the forefront (Grus & Kaslow, 2014). Grus and Kaslow (2014) summarized these as: "behavior and comportsment that reflect the values and attitudes of psychology (Fouad et al., 2009; Hatcher et al., 2013). The essential components include: (1) integrity – honesty, personal responsibility and adherence to professional values; (2) deportment; (3) accountability; (4) concern for the welfare of others; and (5) professional identity."

1. Supervisors strive to model professionalism in their own comportment and interactions with others, and teach knowledge, skills, and attitudes associated with professionalism. Supervisory modeling of professionalism occurs across professional settings. Supervisees' understanding of what is professional or ethical is still developing (Gottlieb, Robinson, & Younggren, 2007). Modeling is a powerful means to teach attitudes and behaviors (e.g., Tarvydas, 1995), including professionalism (Cruess, Cruess, & Steinert, 2009). Supervisors, in vivo, can exemplify virtue, humanism, and honest communication (Grus & Kaslow, 2014, modified from Hatcher et al., 2013).

One important aspect of supervision is to socialize supervisees into a particular profession (e.g., Ekstein & Wallerstein, 1972); to help them learn to "think like" those in that profession.

In interprofessional settings, supervisors model professionalism in cooperative, collaborative, and respectful interaction with team members.

2. Supervisors are encouraged to provide ongoing formative and summative evaluation of supervisees' progress toward meeting expectations for professionalism appropriate for each level of education and training. Modeling alone is insufficient to teach professionalism; it should be embedded in a larger training curriculum incorporating developmentally expected behaviors (Grus & Kaslow, 2014). Supervisees need clear criteria to judge the extent to which they are demonstrating developmentally appropriate professionalism (Fouad et al., 2009; Kaslow et al., 2009) as well as feedback about the extent to which they are meeting those criteria. The knowledge, skills, and attitudes associated with professionalism have been addressed within and across disciplines with

much congruence. These include, “altruism, accountability, benevolence, caring and compassion, courage, ethical practice, excellence, honesty, honor, humanism, integrity, reflection/self-awareness, respect for others, responsibility and duty, service, social responsibility, team work, trustworthiness, and truthfulness” (Grus and Kaslow, 2014).

Domain E: Assessment/Evaluation/Feedback

Assessment, evaluation, and feedback are essential components of ethical supervision (Carroll, 2010; Falender et al., 2004). However, supervisors have been found to provide it relatively infrequently (e.g., Ellis et al., 2014; Friedlander, Siegel, & Brenock, 1989; Hoffman, Hill, Holmes, & Freitas, 2005), which leads to failures in gatekeeping and failures of supervisors in informing supervisees about their competency development (Thomas, 2010), and creates potential for ethical complaints (Falvey & Cohen, 2004; Ladany et al., 1999). To be effective, assessment, evaluation, and feedback need to be directly linked to specific competencies, to observed behaviors, and be timely (APA, 2010, 7.06; Hattie & Timperley, 2007). 1. Ideally, assessment, evaluation, and feedback occur within a collaborative supervisory relationship. Supervisors promote openness and transparency in feedback and assessment, by anchoring such in the competency development of the supervisee.

Establishment and maintenance of the supervisory relationship provide the basis for assessment, evaluation, and feedback. Supervisee disclosure of client data is enhanced by a strong relationship (See Domain C in this document on the Supervisory Relationship.)

2. A major supervisory responsibility is monitoring and providing feedback on supervisee performance. Live observation or review of recorded sessions is the preferred procedure.

Supervisee self-report is the most frequently used source of data on supervisee performance and client/patient progress (e.g., Goodyear & Nelson, 1997; Noelle, 2002; Scott, Pachana, & Sofranoff, 2011). The accuracy of those reports, however, is constrained by human memory and information processing as well as by supervisees’ self-protective distortion and biases, (Haggerty & Hilsenroth, 2011; Ladany, Hill, Corbett, & Nutt, 1996; Pope, Sonne, & Green, 2006; Yourman & Farber, 1996) that result in their not disclosing errors, resulting in the loss of potentially important clinical data. The more direct the access a supervisor has to a supervisee’s professional work, the more accurate and helpful their feedback will likely be. Supervisors should use live observation or audio or video review techniques whenever possible, as these are associated with enhanced supervisee and client/patient outcomes (Haggerty & Hilsenroth, 2011; Huhra, Yamokoski-Maynhart, & Prieto, 2008). Supervisors should not limit work samples only to those identified by the supervisee; some work samples should be selected by supervisors. Review of work samples should be planful and focus on specific competency development and defined supervision goals (Breunlin, Karrer, McGuire, & Cimmarusti, 1988; Hatcher, Fouad, Grus, Campbell, McCutcheon, & Leahy, 2013). In addition, the developmental level of the supervisee should be considered when identifying methods to monitor and provide feedback to the trainee. An organization can reduce legal risk through direct observation of the supervisee’s work (e.g., using live or video observation of sessions) thus satisfying the monitoring standard of care in supervision. 3. Supervisors aspire to provide feedback that is

direct, clear, and timely, behaviorally anchored, responsive to supervisees' reactions, and mindful of the impact on the supervisory relationship.

In delivering feedback, supervisors are sensitive to: (a) the power differential as a function of the supervisory evaluative and gatekeeping roles; (b) culture, diversity dimensions (e.g., gender, race, sexual orientation, socio-economic status) and other sources of privilege and oppression (Ancis & Ladany, 2001; Ryde, 2000; Shen-Miller, Forrest, & Burt, 2012); (c) supervisee developmental level (Stoltenberg & McNeill, 2010); (d) the possibilities of the supervisee experiencing demoralization (Watkins, 1996) or shame (Bilodeau, Savard, & Lecomte, 2012) in response to the feedback; and (e) timing and the amount of feedback that a supervisee can assimilate at any given moment (Westberg & Jason, 1993).

Feedback should occur at frequent intervals, with some positive and corrective feedback in each supervision session so that evaluation is not a surprise (Bennett et al., 2006). In instances when a supervisee exhibits problems in professional competence, supervisors are expected to be courageous and provide this difficult feedback, doing so in a direct and supportive manner. Indirect delivery of difficult feedback to supervisees is not associated with good training outcomes (Hoffman et al., 2005). The difficulty of delivering difficult feedback is especially challenging in multicultural supervision (Burkard, Knox, Clarke, Phelps, & Inman, in press; Shen-Miller et al., 2012). Collaborative conversations among supervisors regarding diversity, consultation, and examination of biases were described as helpful in contextual understanding of individual supervisee development (Shen-Miller et al., 2012).

4. Supervisors recognize the value of and support supervisee skill in self-assessment of competence and incorporate supervisee self-assessment into the evaluation process. Incorporating the use of supervisee self-assessment into the evaluation of supervisees can enhance skill development, provide useful reflection on the delivery of services, and inculcate attitudes of self-assessment as a lifelong learning tool (Wise, Sturm, Nutt, Rodolfa, Schaffer, & Webb, 2010). Research has shown that there are limitations to the accuracy of self-assessments (Dunning, Heath, & Suls, 2004; Gruppen, White, Fitzgerald, Grum, & Woolliscroft, 2000) indicating that the provision of significant feedback to supervisees should be used to enhance supervisee assessment of self-efficacy (Eva & Regehr, 2011).
5. Supervisors seek feedback from their supervisees and others about the quality of the supervision they offer, and incorporate that feedback to improve their supervisory competence.

It is important that supervisors obtain regular feedback about their work. Supervisors may not obtain regular feedback once they are licensed and as a result may tend to overestimate their competence (e.g., Walfish, McAlister, O'Donnell, & Lambert, 2012) and tend to grow in confidence about their abilities, even though that is not necessarily matched by corresponding increases in ability (see Dawes, 1994). Although studies on supervisee nondisclosures (e.g., Ladany et al, 1996; Mehr, Ladany & Caskie, 2010; Yourman & Farber, 1996) suggest difficulty in obtaining candid information from supervisees, it is important that supervisors routinely seek – and utilize – feedback about their own supervision (see e.g., Williams, 1994).

Domain F: Professional Competence Problems

Only a small proportion of supervisees in health service psychology programs demonstrate significant problems in professional competence, but most academic and internship programs report at least one supervisee with competence problems in the previous five years (Forrest et al., 1999). When this occurs it can be helpful to consider the multiple contexts in which problem behavior is embedded (e.g., cultural beliefs, licensure and accreditation, peers, faculty, supervisors) (Forrest et al., 2008). Supervisors must be prepared to protect the wellbeing of clients/patients and the general public, while simultaneously supporting the professional development of the supervisee. They also must be mindful of the effects on the training program itself, as peers typically are aware of trainees with problems of professional competence and often have concerns that those problems are not being addressed (Rosenberg, Getzelman, Arcinue, & Oren, 2005; Shen-Miller et al., 2011; Veilleux et al., 2012).

Supervisors give precedence to protecting the well-being of clients/patients above the training of the supervisee. When supervisees display problems of professional competence decisions made and actions taken by supervisors in response to supervisees' competence problems should be completed in a timely manner (Kaslow, Rubin, Forrest, & et al., 2007). They also are guided by the training program's intentional and well-prepared plans for addressing such problems (Forrest et al., 2013).

1. Supervisors understand and adhere both to the supervisory contract and to program, institutional, and legal policies and procedures related to performance evaluations. Supervisors strive to address performance problems directly.

Effective management of professional competence problems begins with the supervision contract (elements of that contract are presented in the Ethics section of these Guidelines on Supervision) (Goodyear & Rodolfa, 2012; Thomas, 2007). The contract provides prior written notice of the competencies required for satisfactory performance in the supervised experience (Gilfoyle, 2008) as well as the process of evaluation, the procedures that will be followed if the supervisee does not meet the criteria, and procedures available to the supervisee to clarify or contest the evaluation. This contract shall occur in the context of the program communicating clearly the Due Process Guidelines to the supervisees as required by the Commission on Accreditations Guidelines and Principles (Domains A and G). In the event a supervisee is exhibiting performance problems, supervisors seek consultation to ensure understanding of program, institutional, and legal policies and procedures related to performance evaluations.

2. Supervisors strive to identify potential performance problems promptly, communicate these to the supervisee, and take steps to address these in a timely manner allowing for opportunities to effect change.

Supervisors evaluate on an ongoing basis the supervisee's functioning with respect to a broad range of foundational and functional competencies, including professional attitudes and behaviors that are relevant to professional practice. Their determinations about areas in which the supervisee does not meet competence expectations must (a) take into consideration distinctions between normative developmental challenges and significant competence problems (Fouad et al., 2009; Hatcher et al., 2013; Kaslow et al., 2004; Rodolfa et al., 2005) and (b) be attuned to the intersections between

diversity issues and competence (Constantine & Sue, 2007; Kaslow, Rubin, Forrest, & et al., 2007; Shen-Miller et al., 2009). Supervisors also seek consultation from and work in concert with relevant program and institutional participants when addressing potential performance issues.

Especially when potential performance problems are suspected, supervisors directly observe and monitor supervisees' work, and seek input about the supervisee's performance from multiple sources and from more than one supervisor. Supervisee's professional behaviors and attitudes should be carefully documented in writing with dates and specific behaviors included in the record. Documentation is essential throughout the training trajectory in establishing clarity regarding the performance expectations and the supervisee's attaining the requisite competencies and is important in remediation or in adversarial actions.

Once supervisors have identified that a supervisee has professional competence problems, they have an ethical responsibility to discuss these with the supervisee and to develop a plan to remediate those problems (APA, 2010; 7.06). Supervisors do so in a manner that is clear, direct, and mindful of the barriers to assuring that such conversations are effective and likely to maintain the supervisory relationship (Hoffman et al., 2005; Jacobs et al., 2011). Conversations addressing competence problems shall occur with sensitivity to issues of individual and cultural differences (Constantine & Sue, 2007; Shen-Miller et al., 2012).

3. Supervisors are competent in developing and implementing plans to remediate performance problems.

In conjunction with the supervisee and relevant training colleagues, the supervisor develops written documentation of areas in which the supervisee has competence deficits, performance expectations, steps to be taken to address deficits, responsibilities for each party, performance monitoring processes, and the timelines that will be followed (Kaslow, Rubin, Forrest, & et al., 2007). The supervisor will follow the steps outlined in this plan, including the development of timely written evaluations that are anchored in the stipulated performance criteria (Kaslow, Rubin, Forrest, & et al., 2007). Supervisors evaluate their role in the supervisory relationship and adjust their role as needed, providing more direction and oversight and assuring that client/patient welfare is not threatened and appropriate care is provided. These responsibilities need to be balanced with both training and gatekeeping responsibilities.

4. Supervisors are mindful of their role as gatekeeper and take appropriate and ethical action in response to supervisee performance problems.

In most situations, supervisees are ethically and legally entitled to a fair opportunity to remediate the competence problems and continue in their program of study (McAdams & Foster, 2007). Supervisors strive to closely monitor and document the progress of supervisees who are taking steps to address problems of competence. Should the supervisee not meet the stipulated performance levels after completing the agreed-upon remediation steps, attending to supervisee due process, supervisors must consider dismissal from the training program. Supervisors must have a clear understanding of competence problems that reflect unethical and/or illegal behavior that is sufficiently serious to warrant immediate dismissal from the training program (Bodner et al., 2012).

Such considerations occur in the context of the training program's organization's explicit plans for addressing such problems.

Domain G: Ethics, Legal, and Regulatory Considerations

Valuing and modelling ethical behavior and adherence to relevant legal and regulatory parameters in supervision is essential to upholding the highest duty of the supervisor, protecting the public.

Improper or inadequate supervision is the seventh most reported reason for disciplinary actions by licensing boards (ASPPB, 2013c). Supervisees may perceive their supervisors to engage in unethical behavior (Ladany, et al., 1999), sometimes due to misunderstanding the structure of the supervisory relationship and/or a supervisor's failure to secure informed consent. Generally, though, there is some evidence that supervisors and supervisees agree on what comprises ethical behavior (Worthington, Tan, & Poulin, 2002).

1. Supervisors model ethical practice and decision making and conduct themselves in accord with the APA ethical guidelines, guidelines of any other applicable professional organizations, and relevant federal, state, provincial, and other jurisdictional laws and regulations.

Supervisors support the acculturation of the supervisee into the ethics of the profession, their professionalism, and the integration of ethics into their professional behavior (Handelsman, Gottlieb, & Knapp, 2005; Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). Supervisors ensure that supervisees develop the knowledge, skills, and attitudes necessary for ethical and legal adherence. The supervisor is a role model for ethical and legal responsibility. Supervisors discuss values that bear on professional practice, applications of ethical guidelines to specific cases, and the use of ethical decision-making models (Koocher & Keith-Spiegel, 2008; Pope & Vasquez, 2011).

The supervisor is responsible for understanding the jurisdictional laws and regulations and their application to the clinical setting for the supervisee (e.g., duty to warn and protect; Werth, Welfel, & Benjamin, 2009).

Supervisors are knowledgeable of legal standards and their applicability to both clinical practice and to supervision.

2. Supervisors uphold their primary ethical and legal obligation to protect the welfare of the client/patient.

The highest duty of the supervisor is protection of the client/patient (Bernard & Goodyear, 2014). Supervisors balance protection of the client/patient with the secondary responsibility of increasing supervisee competence and professional development. Supervisors ensure that supervisees understand the multiple aspects of this responsibility with respect to their clinical performance (Falender & Shafranske, 2012). Supervisors understand that they are ultimately responsible for the supervisee's clinical work (Bernard & Goodyear, 2014).

3. Supervisors serve as gatekeepers to the profession. Gatekeeping entails assessing supervisees' suitability to enter and remain in the field.

Supervisors help supervisees advance to successive stages of training upon attainment of expected competencies (Bodner, 2012; Fouad et al., 2009). Alternatively, if competencies are not being attained, in collaboration with the supervisee's academic program, supervisors devise action plans with supervisees, with the understanding that if the stated competencies are not achieved, supervisees who are determined to lack sufficient foundational or functional competencies for entry to the profession may be terminated to protect potential recipients of the supervisee's practice (Forrest et al., 2013). Descriptions of such processes are in the training program's or organization's explicit plans for addressing competency problems or the unsuitability of the supervisee for the profession.

4. Supervisors provide clear information about the expectations for and parameters of supervision to supervisees preferably in the form of a written supervisory contract.

A supervision contract serves as the foundation for establishing the supervisory relationship by specifying the roles, tasks, responsibilities of supervisee and supervisor and performance expectations of the supervisee (Bernard & Goodyear, 2014; Osborn & Davis, 2009; Thomas, 2007, 2010). Supervisors convey the value of the points in the supervision contract through conversations with supervisees and may modify the understanding over time as warranted as the goals for supervision change. The contract includes a delineation of the following elements:

a. Content, method, and context of supervision—logistics, roles, and processes

b. Highest duties of the supervisor: protection of the client(s) and gatekeeping for the profession c. Roles and expectations of the supervisee and the supervisor, and supervisee goals and tasks d.

Criteria for successful completion and processes of evaluation with sample evaluation instruments and competency documents (APA, 2010, 2.06) e. Processes and procedures when the supervisee does not meet performance criteria or reference to such if they exist in other documents f. Expectations

for supervisee preparation for supervision sessions (e.g., video review, case notes, agenda preparation) and informing supervisor of clinical work and risk situations g. Limits of confidentiality of supervisee disclosures, behavior necessary to meet ethical and legal requirements

for client/patient protection, and methods of communicating with training programs regarding supervisee performance h. Expectations for supervisee disclosures including personal factors and emotional reactivity (previously described, and worldviews (APA, 2010, 7.04) i. Legal and ethical

parameters and compliance, such as informed consent, multiple relationships, limits of confidentiality, duty to protect and warn, and emergent situation procedures j. Processes for ethical

problem-solving in the case of ethical dilemmas (e.g., boundaries, multiple relationships)

5. Supervisors maintain accurate and timely documentation of supervisee performance related to expectations for competency and professional development.

Keeping supervision records is an important means of documenting the conduct of supervision and supervisee progress (e.g., APA, 2007b; Falvey & Cohen, 2004; Luepker, 2012; Thomas, 2010).

Conclusion

The Guidelines on Supervision address seven domains of supervision and offer specific suggestions in each of these domains that delineate essential practices in the provision of competency-based clinical supervision. The overarching goal of the Guidelines on Supervision is to promote the

provision of quality supervision in health service psychology using a competency framework to enhance the development of supervisee competence while upholding the highest duties of supervision, ensuring the protection of patients, the public, and the profession. The Guidelines on Supervision are intended to be aspirational in nature and are responsive to current trends in education and training in health service psychology. They are considered a living document. Accordingly, they should be reviewed periodically and informed by developments, including the evidence-base regarding clinical supervision.

INTERN EVALUATION AND FEEDBACK

Evaluation and feedback is an integral part of the conduct of the Internship Program. Throughout the Internship year, evaluation and feedback, on a variety of levels, provides the basis for real-time self-appraisal, of Program strengths and weaknesses, and (as-needed) enhancement of all aspects of the Internship Program, as well as of intern work. Throughout the year, the intern's participation in Program evaluation and feedback, can be an impetus for growth in professional independent judgment, function and identity. At the same time, as a bi-directional process, the intern's Evaluations can be an impetus for modification of aspects of the Program, to better fit the needs and capacities of the intern.

Interns receive Evaluations from their Rotation, Assessment, and ongoing outpatient supervisors, discussed in feedback sessions. For ongoing outpatient supervision, assessment and group supervision, evaluation takes place three times/year (i.e. early in year, mid-year, end of year). For the other types of supervision, evaluation takes place at end of the clinical experience (e.g. end of Rotation).

A structured evaluation form, the Psychology Trainee Intern Competency Evaluation Form (see copy provided below), is the centerpiece for these sessions. This form is organized into 9 competency domains, corresponding to the target core competencies of the Internship Program, which are: (1) research skills; (2) ethical and legal standards; (3) multicultural awareness; (4) professional values, attitudes and behaviors; (5) communication and interpersonal skills; (6) assessment skills; (7) models for intervention including evidence-based methods; (8) supervision skills, and (9) consultation and inter-professional/ interdisciplinary skills.

Within each competency domain, 2-6 elements describe the component behaviors and are rated on a scale from 0 – 4, where 0 = R (Needs remediation); 1 = E (Entry level/Continued intensive supervision is needed); 2 = I (Intermediate/Should remain a focus of supervision); 3 = Well Developed Competency (W); 4 = Advanced/Skills comparable to autonomous practice at the licensure level (A). For each Element, examples are listed of the types of behaviors that may typically signify that element. As the forms state, supervisors are advised that while they should use these examples to guide their ratings, it is reasonable to expect a Trainee to demonstrate some, but not all, of the examples listed under a given Element. Furthermore, as a rater, each supervisor should feel free to base their rating of any given Element on additional types of behaviors that are not listed as examples. In addition to giving a score for each Element, supervisors are instructed to provide a Summary Rating Score for each Competency Area, and that the Summary Rating Score does not need to be the numerical average of the Elements. Rather, it should be based on the supervisor's global sense of the Trainee's skill level in that Competency Area.

As previously stated, Interns are evaluated and given feedback throughout the year by their individual supervisors in both formal and informal settings. There are three formal evaluation periods throughout the year – in October, February and May. At this time, the Psychology Trainee Intern Competency Evaluation Form is completed by training supervisors for each intern. On this form, interns are rated on the competencies that they are expected to develop over the course of the training year. Each intern then meets with each of their supervisors to review and discuss the form. The intern also has the option to respond in writing to a supervisor's evaluation forms. In the rare situation when it is recognized that a Trainee needs remedial work, a competency evaluation form will be filled out **immediately**, prior to any deadline for evaluation, and shared with the Trainee and the Training Director. In order to allow the Trainee to gain competency and meet passing criteria for the Traineeship, these areas must be addressed proactively and a remedial plan must be developed in conjunction with the supervisor and Training Director and implemented promptly.

A minimum level of achievement for adequate progress through program for October evaluation period is as such: Minimum level of achievement for adequate progress through program: Intern progress for all competency area summary scores will be rated as a 1-Entry Level (Continued intensive supervision is needed) or 2-Intermediate (Should remain a focus of supervision).

A minimum level of achievement for adequate progress through program for February evaluation period is as such: For at least the majority of competency area summary scores, intern progress will be rated as a 2-Intermediate (Should remain a focus of supervision) or higher.

A minimum level of achievement for adequate progress through program for May evaluation period is as such: The majority of competency areas will be rated as a 3- Well Developed Competency, with some competency areas that need continued improvement rated as a 2- Intermediate (Should remain a focus of supervision). No competency area summary scores will be at a 0-Needs Remediation or 1-Entry Level/Continued intensive supervision is needed. If 3 out of 9 competency summary scores remain at a 0-Needs Remediation or 1-Entry Level (Continue intensive supervision), Training Directors and supervisory staff will discuss whether intern can successfully complete internship training by June 30th deadline.

The Training Director then compiles the feedback and ratings made by the intern's supervisors and completes the Psychology Intern Competency Evaluation Summary Form (see copy provided below), which includes written comments. The Training Director then meets individually with each intern for a summary review meeting that concludes the 4 month review period. During this meeting, the Training Director discusses the evaluations provided by the supervisors regarding the intern's performance, reviews the feedback in aggregate, and makes suggestions for continued training and growth. This process is an opportunity for the training director to provide integrative feedback regarding the collective experience of others who have had significant interactions with the intern. Both parties discuss how the internship experience is progressing and the intern is provided with an opportunity to provide reactions, critiques, and comments about supervision and other aspects of the training program. The training director provides feedback to the intern regarding their satisfactory progression through (or completion of) the internship program at this meeting. If it is deemed necessary, modifications to the training program for a particular intern may be arranged at this time or at any time that the intern or a faculty member deems it necessary. Just as with the Psychology

Trainee Competency Evaluation Form, the intern is also invited to write comments on the Psychology Intern Competency Evaluation Summary Form. Once the Psychology Intern Competency Evaluation Summary Form has been signed by both the trainee and the training director, a copy is sent to the intern's doctoral program. The evaluation forms explicate the rubric used to assess an intern's attainment of competencies, including the minimum level of competency attainment required for successful completion of the internship program.

MOUNT SINAI ST. LUKE'S & WEST PSYCHOLOGY TRAINEE COMPETENCY EVALUATION FORM

Name of Trainee:
Type of Trainee: <input type="checkbox"/> Extern <input type="checkbox"/> Intern <input type="checkbox"/> Post-Doctoral Fellow
Name of Supervisor:
Training Year:
Area(s) of Practice Supervised:

October February May

ASSESSMENT METHOD(S) FOR COMPETENCIES

- | | |
|---|---|
| <input type="checkbox"/> Direct Observation | <input type="checkbox"/> Review of Written Work |
| <input type="checkbox"/> Videotape | <input type="checkbox"/> Review of Raw Test Data |
| <input type="checkbox"/> Audiotape | <input type="checkbox"/> Discussion of Clinical Interaction |
| <input type="checkbox"/> Case Presentation | <input type="checkbox"/> Comments from Other Staff |

There are nine Competency Areas listed in this form. Each Competency Area contains a list of elements comprising the competency. Please rate each element on a scale from 0 – 4. Descriptions of the meaning of the numerical values (0 – 4) are included in the box below.

COMPETENCY ELEMENT RATINGS DESCRIPTIONS	
N/O	No Opportunity to observe the behavior in question
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, as an unlicensed Trainee, supervision is required while in training status.
W	Well Developed Competency A frequent rating at completion of Traineeship. 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 Common rating throughout Traineeship. Routine supervision of each activity is needed.
E	Entry level/Continued intensive supervision is needed Routine, but intensive, supervision is needed.
R	Needs remediation <u>Requires remedial work or corrective action plan.</u>

For each Element, examples are listed of the types of behaviors that may typically signify that element. While you should use these examples to guide your ratings, it is reasonable to expect an Trainee to demonstrate some, but not all, of the examples listed under a given Element. Furthermore, as a rater, you should feel free to base your rating on any given Element on additional types of behaviors that are not listed as examples.

In addition to giving a score for each Element, please provide a Summary Rating Score for each Competency Area. You can use the ratings for each Element to guide your Summary Rating Score; however, the Summary Rating Score does not need to be the numerical average of the Elements. Rather, it should be based on your global sense of the Trainee's skill level in that Competency Area.

COMPETENCY AREA: RESEARCH

Element: Demonstrates the substantially independent ability to critically evaluate and disseminate research or other scholarly activities (e.g., case conference, presentation, publications) at the local (including host institution), regional, or national level.

EXAMPLES: Displays the ability to think critically and scientifically; thoughtfully contributes to conversations about scientific literature; cites research findings during case conferences and

presentations; explains research findings in an articulate and clinically-relevant manner; seeks out and participates in research or other scholarly activities.

_____ **Element: Demonstrates the ability to review, understand and apply scientific and scholarly literature to clinical interventions with diverse populations. EXAMPLES:**

Seeks out relevant research to support clinical interventions; is able to translate scholarly work or research findings into practical therapeutic techniques; demonstrates an awareness of how clinical research may or may not apply to different populations.

_____ **RESEARCH COMPETENCY SUMMARY RATING SCORE** *(not necessarily the average of the elements)*

COMPETENCY AREA: ETHICAL AND LEGAL STANDARDS

_____ **Element: Demonstrates solid knowledge of and acts in accordance with each of the following: the current version of the APA Ethical Principles of Psychologists and Code of Conduct, as well as relevant laws, regulations, rules, and policies governing health service psychology at the organizational, local, state, regional, and federal levels; and relevant professional standards and guidelines. EXAMPLES:** Demonstrates knowledge of typical legal issues such as HIPAA, confidentiality, and child abuse reporting; demonstrates behavior consistent with ethical and legal standards in all professional activities. Demonstrates reliable judgment about when consultation is needed.

_____ **Element: Recognizes ethical dilemmas as they arise, and applies ethical decision-making processes in order to resolve dilemmas. EXAMPLES:** Spontaneously and consistently is able to recognize and proactively manage ethical dilemmas in professional service, training and research. Demonstrates the ability to understand an ethical dilemma from multiple perspectives and apply relevant ethic codes and principles in order to make sound decisions. Demonstrates reliable judgment about when consultation is needed.

_____ **Element: Conducts self in an ethical manner in all professional activities.**

EXAMPLES: Smooth working relationships, handles differences openly, tactfully and effectively. Adheres to the APA Ethical Principles and Code of Conduct.

_____ **ETHICAL AND LEGAL STANDARDS COMPETENCY SUMMARY RATING Score**

(not necessarily the average of the elements)

COMPETENCY AREA: INDIVIDUAL AND CULTURAL DIVERSITY

_____ **Element: Demonstrates an understanding of how their own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves. EXAMPLES:** Accurately reflects on and shows awareness of how one's various identities and experiences have impacted one's worldview; articulates how one's views, history or biases may impact one's understanding of others, including clients and colleagues; demonstrates awareness of one's own positions of power and privilege relative to others and how this can impact interpersonal interactions; requests appropriate

supervision when one feels they are acting on a bias; demonstrates openness to exploring one's own biases and worldviews.

_____ **Element: Demonstrates knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities including research, training, supervision/consultation and service.** *EXAMPLES:* Recognizes various aspects of identities and how they intersect (e.g., race, gender, sexual orientation, religion); consistently demonstrates awareness of how others' various identities may inform their understanding of themselves, the world, and clinical interventions; demonstrates an understanding of how therapist and client differences may or may not impact treatment.

_____ **Element: Demonstrates the ability to integrate awareness and knowledge of individual and cultural difference in the conduct of professional roles (e.g., research, services, and other professional activities). This includes the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers; also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews create conflict with their own.** *EXAMPLES:* Utilizes assessment and intervention methods that are culturally appropriate and modifies those that are not; recognizes when more information is needed regarding diversity factors and seeks out empirical knowledge and information; demonstrates awareness of own limits and expertise and seeks out guidance; develops a framework for culturally competent care that involves assessment of one's one perspective/biases, an understanding of others in the context of their various identities and cultural factors, and an ability to openly and non-defensively discuss issues relating to individual and cultural diversity with clients, peers and supervisors. Reliably applies this framework in all professional activities.

_____ **Element: Demonstrates the ability to independently apply their knowledge and approach in working effectively with the range of diverse individuals and groups encountered during Traineeship.** *EXAMPLES:* Proactively seeks to understand and apply framework for culturally competent care; does not need to be prompted to view others in the context of their various identities and cultural and sociopolitical context.

_____ **INDIVIDUAL AND CULTURAL DIVERSITY COMPETENCY SUMMARY RATING SCORE**

(Not necessarily the average of the elements)

COMPETENCY AREA: PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS

_____ **Element: Behaves in ways that reflect the values and attitudes of psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others.** *EXAMPLES:* Demonstrates understanding of one's role as a psychology Trainee and emerging psychologist; acts respectfully toward peers, colleagues, supervisors and agency staff in verbal and non-verbal communication; meets expected deadlines for work; is punctual and reliable for all scheduled activities; assumes responsibility for lapses in professionalism or accountability; remains curious and open to new information; displays empathy and compassion toward others.

_____ **Element: Actively engages in self-reflection regarding one's personal and professional functioning; engages in activities to maintain and improve performance, well-being, and professional effectiveness.** *EXAMPLES:* Is honest and open about one's own limitations or areas of growth; engages in multiple methods of self-assessment and self-reflection (e.g., through supervision, peer feedback, introspection); develops and follows through on concrete plans to improve; consciously and purposefully conducts oneself in a way that is appropriate for one's professional role and modifies behavior based on context and setting.

_____ **Element: Actively seeks and demonstrates openness and responsiveness to feedback and supervision.** *EXAMPLES:* Demonstrates openness and responsiveness to feedback and supervision; requests feedback on professional conduct regarding both areas of strength and areas of growth; acts on feedback given by others by making purposeful efforts to improve

_____ **Element: Responds professionally in increasingly complex situations with a greater degree of independence as they progress across levels of training.** *EXAMPLES:* Demonstrates the overall ability to integrate feedback about professionalism over the course of training; maintains professional deportment in the face of challenging professional interactions; demonstrates the ability to think through and problem-solve complex professional interactions; seeks appropriate guidance and/or supervision on complex professional interactions.

_____ **PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS COMPETENCY SUMMARY RATING**

Score *(not necessarily the average of the elements)*

COMPETENCY AREA: COMMUNICATIONS AND INTERPERSONAL SKILLS

_____ **Element: Develops and maintains effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services.** *EXAMPLES:* Develops productive and collegial relationships with peers, supervisors and agency staff; creates, manages and effectively terminates working relationships with patients and families; displays compassion and empathy towards others, including those who are dissimilar from oneself; is able to effectively and reflectively work through disagreements with others.

_____ **Element: Produces and comprehends oral, nonverbal, and written communications that are informative and well-integrated; demonstrates a thorough grasp of professional language and concepts.** *EXAMPLES:* Produces written work that is clear, concise and informative; uses professional language competently; explains clinical material in an informative and succinct manner when presenting to other professionals both one-on-one and in groups; shows an understanding of how to modify communication style based on the setting and audience; listens respectfully to others.

_____ **Element: Demonstrates effective interpersonal skills and the ability to manage difficult communication well.** *EXAMPLES:* Actively attempts to understand and acknowledges others' perspectives, including colleagues and clients; reflects on and demonstrates awareness about one's presentation in group settings; demonstrates openness to feedback

from peers and supervisors; maintains poise when faced with conflict; actively applies problem-solving strategies when conflict arises.

COMMUNICATIONS AND INTERPERSONAL SKILLS COMPETENCY SUMMARY RATING Score

(Not necessarily the average of the elements)

COMPETENCY AREA: ASSESSMENT

Element: Selects and applies assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collects relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient. *EXAMPLES:* Clarifies and gains full understanding of referral question; Appropriately selects testing measures based on referral questions, presenting problems and ongoing assessment findings; administers testing instruments with accuracy and efficiency; scores measures correctly.

Element: Interprets assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations while guarding against decision-making biases, distinguishing the aspects of the assessment that are subjective from those that are objective.

EXAMPLES: Skillfully and efficiently interprets test data; synthesizes findings from various measures into an integrated whole; is sensitive to cultural considerations in interpretation of test results.

Element: Communicates orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences. *EXAMPLES:* Oral communication is clear, thorough and geared toward the audience; reports are informative and concise; findings are integrated in a clear and thoughtful manner; findings are used to make strong recommendations.

Element: Demonstrates current knowledge of diagnostic classification systems, functional and dysfunctional behaviors, including consideration of client strengths and psychopathology. *EXAMPLES:* Is able to rule in or out diagnoses taking into account test data, observation, and clinical interview. Utilizes observation and test data to pinpoint areas of strength from cognitive, neurological, language, characterological lenses

Element: Demonstrates understanding of human behavior within its context (e.g., family, social, societal and cultural) *EXAMPLES:* Considers family background and pertinent family and medical history when making diagnostic explanations; Can compare and contrast as well as predict patient functioning and behavior in various settings (e.g. school, one on one settings, job setting) based on test data and conceptualization

Element: Demonstrates the ability to apply the knowledge of functional and dysfunctional behaviors including context to the assessment and/or diagnostic process *EXAMPLES:* Observes and includes relevant behavioral observations and links behaviors from session to session to develop understanding of patterned behaviors during

testing sessions; develops a working understanding of typical development in order to compare and contrast patient's behaviors to what is expected of patient based on peers

_____ **ASSESSMENT COMPETENCY SUMMARY RATING SCORE** *(not necessarily the average of the elements)*

COMPETENCY AREA: INTERVENTION

_____ **Element: Establish and maintains effective relationships with the recipients of psychological services.** *EXAMPLES:* Establishes rapport with patients, including those who have a range of backgrounds and presenting problems; manages ruptures in therapeutic relationships; terminates therapy relationships with intentionality and sensitivity.

_____ **Element: Develops evidence-based intervention plans specific to the service delivery goals.** *EXAMPLES:* Identifies clear treatment targets that incorporate clients' wishes; creates measurable treatment objectives; base treatment plans on scientific and scholarly literature.

_____ **Element: Implement therapeutic interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables.** *EXAMPLES:* Creates intervention plans that draw from the scientific literature; uses assessment findings to inform treatment goals; creates case conceptualizations and treatment plans that take into account diversity characteristics and contextual variables.

_____ **Element: Demonstrates the ability to apply the relevant research literature to clinical decision making.** *EXAMPLES:* Independently and consistently draws upon the relevant research literature to inform clinical decision making; demonstrates an understanding of how to determine if research literature is relevant to a given client.

_____ **Element: Modifies and adapts evidence-based approaches effectively when a clear evidence-base is lacking.** *EXAMPLES:* Demonstrates the ability to identify when there is a lack of evidence base for a particular client or presenting problem; understands when research evidence may not be relevant to clients with various diversity characteristics; shows creativity and flexibility in modifying treatment approaches.

_____ **Element: Evaluate intervention effectiveness, and adapt intervention goals and methods consistent with ongoing evaluation.** *EXAMPLES:* Evaluates intervention effectiveness on an ongoing basis; is objective in determining treatment effectiveness; shows creativity and flexibility in adapting treatment goals and approaches when progress is lacking.

_____ **Element: Demonstrate the ability to conceptualize a case from a biopsychosocial perspective.**

EXAMPLES: Thoroughly assesses all relevant domains of functioning and relevant history in order to build case conceptualization; synthesizes information to form coherent and integrated case conceptualization.

_____ **INTERVENTION COMPETENCY SUMMARY RATING SCORE** *(not necessarily the average of the elements)*

COMPETENCY AREA: SUPERVISION

- _____ **Element: Applies supervision knowledge in direct or simulated practice with psychology trainees, or other health professionals.** *EXAMPLES:* Supervision and guidance is provided intentionally and based on knowledge of models of supervision.
- _____ **Element: Develops an understanding of the supervisor role and skills for conducting supervision.** *EXAMPLES:* Demonstrates an emerging articulation of one's own supervision style; maintains appropriate boundaries related to supervision; provides helpful clinical and/or professional guidance to supervisees.
- _____ **Element: Demonstrates awareness of strengths and limitations as a supervisor; appropriately seeks out guidance.** *EXAMPLES:* Clearly recognizes areas of growth as a supervisor; demonstrates an awareness of strengths as an emerging supervisor; appropriately seeks out guidance when needed.
- _____ **SUPERVISION COMPETENCY SUMMARY RATING SCORE** *(not necessarily the average of the elements)*

COMPETENCY AREA: CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

- _____ **ELEMENT: Demonstrates knowledge and respect for the roles and perspectives of other professions.** *EXAMPLES:* Demonstrates understanding of role of psychologist on interdisciplinary team; recognizes and shows respect for discipline-specific specialized knowledge.
- _____ **ELEMENT: Applies knowledge of and respect for the roles and perspectives of other professions in direct consultation with individuals and their families, other health care professionals, interprofessional groups, or systems related to health and behavior.** *EXAMPLES:* Maintains appropriate boundaries with other health professionals through demonstrating respect for their discipline-specific knowledge; recognizes limits of one's own professional knowledge when working in a medical setting; seeks out advice and guidance from other professionals on behalf of clients.
- _____ **Element: Integrate the perspective of psychological health services into an interdisciplinary team-based approach.** *EXAMPLES:* Demonstrates an understanding of the unique contributions that can be make as a psychologist on an interdisciplinary team; communicates unique perspective as a psychologist to other professionals in an informative and succinct manner.
- _____ **CONSULTATION AND INTERPROFESSIONAL/INDERDISCIPLINARY COMPETENCY SUMMARY RATING SCORE** *(not necessarily the average of the elements)*

SUPERVISOR COMMENTS

Summary of Strengths (List at least two areas of strength):

Areas of Additional Development or Remediation, including Recommendations (List at least two areas that can use further development)

CONCLUSIONS

REMEDIAL WORK INSTRUCTIONS: In the rare situation when it is recognized that an Trainee needs remedial work, a competency evaluation form should be filled out **immediately**, prior to any deadline for evaluation, and shared with the Trainee and the Training Director. In order to allow the Trainee to gain competency and meet passing criteria for the Traineeship, these areas must be addressed proactively and a remedial plan must be developed in conjunction with the supervisor and Training Director and implemented promptly.

GOAL FOR TRAINEE EVALUATIONS DONE AT OCTOBER EVALUTION PERIOD

Minimum level of achievement for adequate progress through program: Intern progress for all competency area summary scores will be rated as a 1-Entry Level (Continued intensive supervision is needed) or 2-Intermediate (Should remain a focus of supervision).

_____ The Trainee **HAS** successfully completed the above goal as rated by this supervisor. We have reviewed this evaluation together.

_____ The Trainee **HAS NOT** successfully completed the above goal as rated by this supervisor. We have reviewed this evaluation together. Ratings that do not meet the minimum level of achievement for adequate progress through the program will be reviewed by the Training Director and all supervisors working with this Trainee. At the end of this review process, the Training Director will notify the Trainee what plan, if any, is needed to address the Trainee's need for remediation.

GOAL FOR TRAINEE EVALUATIONS DONE AT FEBRUARY EVALUTION PERIOD

Minimum level of achievement for adequate progress through program: For at least the majority of competency area summary scores, intern progress will be rated as a 2-Intermediate (Should remain a focus of supervision) or higher.

_____ The Trainee **HAS** successfully completed the above goal as rated by this supervisor. We have reviewed this evaluation together.

_____ The Trainee **HAS NOT** successfully completed the above goal as rated by this supervisor. We have reviewed this evaluation together. For intern competency areas rated as a 1- Entry Level (Continued intensive supervision is needed), the Training Director or Associate Director will discuss ways to improve trainee progress with supervisors. If 3 out of 9 competency area summary scores are at a 1-Entry Level (Continued intensive supervision is needed) or lower, Training Director or Associate Director will discuss a remediation plan with clear behavioral targets with supervisors and the intern.

GOAL FOR TRAINEE EVALUATIONS DONE AT MAY EVALUATION PERIOD

Minimum level of achievement for completion of program: The majority of competency areas will be rated as a 3- Well Developed Competency, with some competency areas that need continued improvement rated as a 2- Intermediate (Should remain a focus of supervision). No competency area summary scores will be at a 0-Needs Remediation or 1-Entry Level/Continued intensive supervision is needed. If 3 out of 9 competency summary scores remain at a 0-Needs Remediation or 1-Entry Level (Continue intensive supervision), Training Directors and supervisory staff will discuss whether intern can successfully complete internship training by June 30th deadline.

Supervisor _____

Date _____

Trainee Comments Regarding Competency Evaluation (if any):

I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.

Trainee _____

Date _____

Parts of this form are adapted from Janet Willer, PhD of the VA Chicago Health Care System; the American Psychological Association's Competency Benchmarks in Professional Psychology Readiness to Practice Level Rating Form; Michele Goyette-Ewing, PhD of the Yale Child Study Center Psychology Training Program

MOUNT SINAI ST. LUKE'S & WEST PSYCHOLOGY TRAINEE COMPETENCY EVALUATION SUMMARY FORM

Trainee:		Training Director:	
Type of Trainee:	<input type="checkbox"/> Extern	<input type="checkbox"/> Trainee	<input type="checkbox"/> Post-Doctoral Fellow
Training Year:			
Date:			
	<input type="checkbox"/> October	<input type="checkbox"/> February	<input type="checkbox"/> May

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, as an unlicensed Trainee, supervision is required while in training status.
- W Well Developed Competency**
 A frequent rating at completion of Traineeship. 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**

 Common rating throughout Traineeship. Routine supervision of each activity is needed.
- E Entry level/Continued intensive supervision is needed**

 More common rating at the beginning of Traineeship or in an area of practice that is new to an Trainee.
- R Needs remediation**

The Mount Sinai St. Luke's/West Psychology Training Program aims to prepare Trainees in nine competency areas. During formal evaluation periods, each Trainee is given an overall, global summary rating score by each supervisor who supervises them on each competency area. The information below is the average summary score that the Trainee received across applicable supervisors.

COMPETENCE IN RESEARCH: Uses scholarly literature to inform professional practice; disseminates scientific literature through case conferences, presentations, and/or publications.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN ETHICAL AND LEGAL STANDARDS: Understands and applies ethical and legal standards in all areas of professional practice and conduct.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN INDIVIDUAL AND CULTURAL DIVERSITY: Understands one's own self and biases; Knowledge of current theoretical and empirical knowledge base related to diversity issues; demonstrates an ability to integrate and apply this knowledge in working with individuals from diverse backgrounds.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN PROFESSIONAL VALUES, ATTITUDES, AND BEHAVIORS: Behaves in ways that reflect the values of psychology; engages in self-reflection; actively attempts to improve; demonstrates openness and responsiveness to feedback; responds professionally in increasingly complex situations.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN COMMUNICATIONS AND INTERPERSONAL SKILLS: Develops and maintains effective working relationships; produces effective verbal and written communication; demonstrates effective interpersonal skills.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN ASSESSMENT: Selects appropriate assessment methods; integrates findings; effectively interprets test data; articulately communicates findings; educates non-psychology staff on issues of standardized assessment; demonstrates current knowledge of diagnostic classification systems, functional and dysfunctional behaviors, including consideration of client strengths and psychopathology; demonstrates understanding of human behavior within its context (e.g., family, social, societal and cultural); demonstrates the ability to apply the knowledge of functional and dysfunctional behaviors including context to the assessment and/or diagnostic process

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN INTERVENTION: Effectively establishes rapport; uses evidence-based interventions appropriately; develops clear and thoughtful treatment plans; forms integrated case conceptualizations

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN SUPERVISION: Applies supervision knowledge; has an awareness of one's own developing strengths and weaknesses as a supervisor.

AVERAGE SUMMARY SCORE: _____

COMPETENCE IN CONSULTATION AND INTERPROFESSIONAL/ INTERDISCIPLINARY SKILLS:

Demonstrates knowledge and respect for roles and perspectives of professionals from other disciplines; makes unique contributions to interdisciplinary teams from the perspective of psychology.

AVERAGE SUMMARY SCORE: _____

TRAINING DIRECTOR COMMENTS

SUMMARY OF STRENGTHS

AREAS OF ADDITIONAL DEVELOPMENT OR REMEDIATION, INCLUDING RECOMMENDATIONS

For October and February Evaluation Periods:

_____ The Trainee is adequately progressing toward attainment of Traineeship competencies

_____ The Trainee **IS NOT** adequately progressing toward attainment of Traineeship competencies

**If Trainee IS NOT adequately progressing toward attainment of Traineeship

competencies, see attached letter outlining specific elements of specific competencies that need remediation and a written remediation plan.

For the May Evaluation Period:

_____ The Trainee has adequately attained Traineeship competencies

_____ The Trainee **HAS NOT** adequately attained Traineeship competencies

If Trainee **HAS NOT attained Traineeship competencies, see attached letter outlining the remediation plan that was attempted, why it was not successful and what further steps, if any, will be taken at this time.

Training Director _____

Date _____

TRAINEE COMMENTS REGARDING COMPETENCY EVALUATION (IF ANY):

I have received a full explanation of this evaluation. I understand that my signature does not necessarily indicate my agreement.

Trainee _____

Date _____

SUPERVISOR AND PROGRAM EVALUATION AND FEEDBACK

As our program believes evaluation is bidirectional, interns are also expected and encouraged to evaluate their supervisors, program leadership, and the internship as a whole. The program evaluates the effectiveness of its training and makes changes as follows:

- A.) The directors of training meet three times a year with each trainee. At these meetings, students are asked to give feedback on each supervisor, their rotations, their didactics and the general training experience. When a problem area is highlighted, the Directors and Associate Directors of training will discuss this feedback and intervene or make changes as needed.
- B.) At mid-year and at the end of the year, trainees are asked to evaluate each supervisor and rotation using our evaluation forms. Concomitantly, supervisors are asked to evaluate their supervisees and to give them feedback. These forms are then reviewed by the Director and Associate Directors of training. If needed, supervisors and supervisees will be encouraged to process any problems or issues that have arisen. If that communication is not effective or does not lead to a resolution, the Director and/or Associate Directors of Training will intervene.
- C.) At the end of the training year, students are invited to give detailed written and oral feedback about their training experience and are asked to suggest ways to modify or improve the training program.
- D.) At the end of each year, trainees fill out confidential questionnaires soliciting their feedback about seminar didactics. Based on this information, certain didactics are removed, some added and some improved upon.

Below are copies of the supervisor rating (trainee's evaluation of supervisor) form, Associate Director and Training Director rating form, rotation form, course evaluation form (to be completed for each of the major courses and for each of the main course modules), and program evaluation form:

SUPERVISOR RATING FORM

Name of Supervisor

Date

Type of Supervision (e.g. individual outpatient psychotherapy, testing and assessment, etc.)

As part of our ongoing evaluation and improvement of our Program, please take a moment to reflect on your work with your Supervisor. Only the Training Director/ Associate Directors will read your responses. Supervisors will receive feedback only about their aggregate work – in all of the supervision, mentoring and teaching they provide.

The first set of questions asks about the extent to which your work with your Supervisor is helping/has helped you in the various areas listed below. Please use the scale from 1 (Not at all) to 5 (extremely) to answer. (Please make these ratings in comparison to your experiences with past and present supervisors).

To what extent did the/is the Supervisor help you/helping you to:

- | | | | | | | |
|----|--|---------------------|-----------------|--------------|------------------|-----|
| 1. | Conduct comprehensive intake, psychiatric history and psychosocial evaluation? | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 2. | Determine DSM Multiaxial Diagnosis? | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 3. | Conduct mental status examination? | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

4. Formulate treatment goals and treatment plans?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
5. Communicate diagnostic information, treatment plans and treatment progress to patients?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
6. Communicate diagnostic information, treatment plans and treatment progress to collaterals?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
7. Conduct psychological interventions according to evidence-based manuals?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

8. Establish and maintain therapeutic alliance?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
9. Establish and maintain therapeutic frame?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
10. Develop psychodynamic formulations?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
11. Conceptualize major aspects of transference?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
12. Conceptualize major aspects of own countertransference?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
13. Use theoretical, empirical and lay literature to understand major, distinguishing values, norms and life situations of people of diverse ethnicities and/or cultures?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
14. Use theoretical, empirical and lay literature to understand major, distinguishing values, norms and life situations of people of different genders, sexual identities and sexual orientations?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

15. Use theoretical, empirical and lay literature to tailor interventions to the values, norms and life situations of people of different ethnicities, cultures, genders, sexual identities and sexual orientations?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
16. Use theoretical, empirical and lay literature to understand age-appropriate values, norms and life situations of people at different developmental stages?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
17. Use theoretical, empirical and lay literature to tailor interventions to the age-appropriate values, norms and life situations of people at different developmental stages?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
18. Use theoretical, empirical and lay literature to understand the values, norms and life situations of people with different psychiatric disorders?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
19. Use theoretical, empirical and lay literature to tailor interventions to the values, norms and life situations of people with different psychiatric disorders?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
20. Use theoretical literature to conceptualize interventions?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
21. Use empirical research to identify evidence-based interventions?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|-----|
| 1 | 2 | 3 | 4 | 5 | N/A |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

22. Assess and manage acute risk (e.g. suicidal risk, homicidal risk, risk of abuse, risk of psychotic decompensation, etc.)?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
23. Conduct crisis intervention?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
24. Initiate emergency safety procedures and rapidly access emergency staff (e.g. psychiatrist, security personnel, etc.) and resources (e.g. CPEP, etc.)?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
25. Develop knowledge and skills to advocate and navigate systems on behalf of patients?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
26. Administer and interpret results of psychological testing, according to evidence-based protocol?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
27. Write psychological testing reports adequately and punctually?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
28. Make case presentations effectively in clinical conferences?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
29. Consult with (mental health care, health care, and other) service providers?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

30. Work collaboratively in a multidisciplinary team?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
31. Conceptualize the supervisory process?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
32. Openly and constructively use supervision?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
33. Understand fundamental elements of ethical practice?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
34. Function independently, within parameters of supervised experience?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
35. Complete clinical documents adequately and punctually?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely
36. Manage the stress of full-time clinical work?
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

The next set of questions asks about your experience of your Supervisor. Please use the scale from 1 (Not at all) to 5 (extremely) to answer. (Please make these ratings in comparison to your experiences with past and present supervisors).

To what extent is/was your Supervisor:

- | | | | | | | |
|----|--|---------------------|-----------------|--------------|------------------|-----|
| 1. | Attentive to supervisory discussion | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 2. | Easy to discuss clinical material with | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 3. | Respectful | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 4. | Responsive to your personal and professional needs | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 5. | Supportive of your personal and professional growth | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 6. | A source of ongoing, constructive feedback | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 7. | Knowledgeable and instructive about theory and technique | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

8. Available (for supervision and for emergency consultation)
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

9. Punctual for supervision sessions
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

10. Professional
1 2 3 4 5 N/A
Not at all A little bit Somewhat A lot Extremely

TRAINING DIRECTOR/ASSOCIATE TRAINING DIRECTOR RATING FORM

Name of Training Director/Associate Training Director

Date

As part of our ongoing evaluation and improvement of our Program, please take a moment to reflect on your experiences with the Training Director/Associate Training Directors. Only the Director of Education and Training, Department of Psychiatry and Behavioral Health, will read your responses. Feedback will be given to the Training Director/Associate Training Director in the aggregate, from all Interns.

Please use the scale from 1 (Not at all) to 5 (extremely) to answer the questions below. (Please make these ratings in comparison to your experiences with past and present training directors in your graduate education and training).

To what extent are/were your Training Director/Associate Training Director:

- | | | | | | | |
|----|---|---------------------|-----------------|--------------|------------------|-----|
| 1. | Attentive to Program discussion | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 2. | Easy to discuss Program experiences with | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 3. | Respectful | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 4. | Responsive to your personal and professional needs | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| 5. | Supportive of your personal and professional growth | | | | | |
| | 1 | 2 | 3 | 4 | 5 | N/A |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

- | | | | | | | |
|-----|--|---------------------|-----------------|--------------|------------------|-----|
| 6. | A source of ongoing, constructive feedback | | | | | N/A |
| | 1 | 2 | 3 | 4 | 5 | |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| | | | | | | |
| 7. | Knowledgeable and instructive about theory and technique | | | | | N/A |
| | 1 | 2 | 3 | 4 | 5 | |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| | | | | | | |
| 8. | Available (for supervision and for emergency consultation) | | | | | N/A |
| | 1 | 2 | 3 | 4 | 5 | |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| | | | | | | |
| 9. | Punctual for meetings | | | | | N/A |
| | 1 | 2 | 3 | 4 | 5 | |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
| | | | | | | |
| 10. | Professional | | | | | N/A |
| | 1 | 2 | 3 | 4 | 5 | |
| | <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

ROTATION EVALUATION

Please take a moment to reflect on your Rotation experience.

Rotation Name: _____

1. What do you like about the Rotation?

2. What do you dislike about the Rotation?

3. What suggestions do you have for improving the Rotation?

Please use the following scales to rate your experience of the different aspects of the Rotation:

How satisfied were you (to date) with the clinical experiences on the Rotation?

Not at all A little bit Somewhat Quite a bit Extremely

How satisfied were you with the supervision on the Rotation?

Not at all A little bit Somewhat Quite a bit Extremely

How manageable was the workload on the Rotation?

Not at all A little bit Somewhat Quite a bit Extremely

Overall, how satisfied are you with the quality of your rotation experience?

Not at all A little bit Somewhat Quite a bit Extremely

Course Evaluation Form

Name of Teacher(s): _____ Dates of Course: _____

Name of Course Module: _____

As part of our ongoing evaluation and improvement of our Program, please take a moment to reflect on the above Course Module. Only the Training Director/Associate Directors will read your responses. Teachers will receive feedback only in the aggregate – from all the Interns.

The first set of questions asks about the extent to which the Course Module helped you in the various areas listed below. Please use the scale from 1 (Not at all) to 5 (extremely) to answer. (Please make these ratings in comparison to your experiences with past and present brief clinical Courses).

To what extent did the Course Module help you to:

1. Conduct comprehensive intake, psychiatric history and psychosocial evaluation?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

2. Determine DSM Multiaxial Diagnoses?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

3. Conduct mental status examination?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

4. Formulate treatment goals and treatment plans?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

5. Communicate diagnostic information, treatment plans and treatment progress to patients?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

6. Communicate diagnostic information, treatment plans and treatment progress to collaterals?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

7. Conduct psychological interventions according to evidence-based manuals?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

8. Establish and maintain therapeutic alliance?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

9. Establish and maintain therapeutic frame?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

10. Develop psychodynamic formulations?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

11. Conceptualize major aspects of transference?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

12. Conceptualize major aspects of own countertransference?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

13. Use theoretical, empirical and lay literature to understand major, distinguishing values, norms and life situations of people of diverse ethnicities and/or cultures?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

14. Use theoretical, empirical and lay literature to understand major, distinguishing values, norms and life situations of people of different genders, sexual identities and sexual orientations?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

15. Use theoretical, empirical and lay literature to tailor interventions to the values, norms and life situations of people of different ethnicities, cultures, genders, sexual identities and sexual orientations?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

16. Use theoretical, empirical and lay literature to understand age-appropriate values, norms and life situations of people at different developmental stages?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

17. Use theoretical, empirical and lay literature to tailor interventions to the age-appropriate values, norms and life situations of people at different developmental stages?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

18. Use theoretical, empirical and lay literature to understand the values, norms and life situations of people with different psychiatric disorders?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

19. Use theoretical, empirical and lay literature to tailor interventions to the values, norms and life situations of people with different psychiatric disorders?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

20. Use theoretical literature to conceptualize interventions?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

21. Use empirical research to identify evidence-based interventions?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

22. Assess and manage acute risk (e.g. suicidal risk, homicidal risk, risk of abuse, risk of psychotic decompensation, etc.)?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

23. Conduct crisis intervention?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

24. Initiate emergency safety procedures and rapidly access emergency staff (e.g. psychiatrist, security personnel, etc.) and resources (e.g. CPEP, etc.)?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

25. Develop knowledge and skills to advocate and navigate systems on behalf of patients?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

26. Administer and interpret results of psychological testing, according to evidence-based protocol?

1	2	3	4	5	NA
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>	

27. Write psychological testing reports adequately and punctually?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
28. Make case presentations effectively in clinical conferences?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
29. Consult with (mental health care, health care, and other) service providers?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
30. Work collaboratively in a multidisciplinary team?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
31. Conceptualize the supervisory process?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
32. Openly and constructively use supervision?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
33. Understand fundamental elements of ethical practice?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
34. Function independently, within parameters of supervised experience?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
35. Complete clinical documents adequately and punctually?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |
36. Manage the stress of full-time clinical work?
- | | | | | | |
|-------------------|---------------------|-----------------|--------------|------------------|----|
| 1 | 2 | 3 | 4 | 5 | NA |
| <i>Not at all</i> | <i>A little bit</i> | <i>Somewhat</i> | <i>A lot</i> | <i>Extremely</i> | |

The next set of questions asks about your experience of the Teacher(s). Please use the scale from 1 (Not at all) to 5 (extremely) to answer. (Please make these ratings in comparison to your experiences with past and present Teachers in brief clinical courses).

To what extent were the Teachers:

1. Interesting?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

2. Easy to discuss clinical and didactic material with?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

3. Responsive?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

4. Clear and organized?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

5. Knowledgeable and instructive about theory and technique?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

6. Punctual for course sessions?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

7. Professional?

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

The next set of questions asks about your experience of the Course Module. Please indicate how much you agree or disagree with each of the following statements by circling a number on the scale below each statement.

1. This topic was relevant to my clinical work.

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

2. I learned a lot from this Course Module.

1	2	3	4	5
<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Extremely</i>

St. Luke's/West Internship Overall Program Evaluation

Looking back on the Internship experience, please reflect on your experience of each major aspect of the Program. Please respond frankly – as your feedback will help us improve the Internship Program.

1. CLINICAL ROTATIONS:

Thinking about your rotations, what were the strengths and weaknesses of each? What suggestions do you have for improvement?

1.1 Inpatient Rotation (Clark 8)

1.2 Inpatient Rotation (7G)

1.3 CITPD

1.4 PRC

1.5 CARES

1.6 AI

1.7 Testing and Assessment (Adult Track)

1.8 Parent – Infant Center Screenings (Child Track)

1.9 Testing and Assessment (Child Track)

How satisfied were you with the quality of the Rotations?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

To what degree do you feel your clinical skills have improved as a result of your experiences in the rotations?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

Overall how satisfied were you with the supervision you received on your rotations?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

2. OUTPATIENT EXPERIENCE

Thinking about the different aspects of your outpatient clinic work, what did you like and dislike about them? What suggestions do you have for improving them?

2.1 Individual psychotherapy

2.2 Group psychotherapy

2.3 Family therapy

2.4 Parent-Infant Treatment

2.5 How satisfied were you with the quality of your clinical experience in the Outpatient Clinic?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

To what degree do you feel your clinical skills have improved as a result of your experience in the OPC?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

Overall how satisfied were you with the supervision you received on your outpatient work?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

3. SUPERVISION

Thinking more specifically about your supervision experiences, what did you like and dislike about them? What suggestions do you have for improving them?

3.1 Individual outpatient supervision

3.2 Group outpatient supervision

3.3 Family therapy supervision

3.4 Assessment supervision

3.5 CBT supervision

How satisfied were you with the quality of the supervision you received?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

Was the amount of supervision adequate?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

Was feedback to you constructive and timely?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

4. COURSES –

Thinking about the different Course series, what did you like and dislike about them? What suggestions do you have for improving them?

- 4.1 Tuesday and Thursday Series
- 4.2 Monday Series
- 4.3 Wednesday Professional Development Lunch Series
- 4.4 Psychotherapy Case Conference
- 4.5 Psychopharmacology Series
- 4.6 Psychotherapy Course (CFI)
- 4.7 Neuropsychological Testing Course (CFI0)

How satisfied were you with the quality of the Courses?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

5. PROCESS GROUP

Thinking about your process group experience, what did you like and dislike about it? What suggestions do you have for improving it?

How satisfied were you with the quality of your process group experience?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

6. TRAINING DIRECTOR/ASSOCIATE DIRECTOR

Thinking about your relationships with the Training Director and Associate Training Director, what did you like and dislike about them? What suggestions would you have for improving them?

How satisfied were you with the quality of your relationships with the Training Director and Associate Training Director?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

7. OVERALL INTERNSHIP EXPERIENCE

Thinking about the Internship as a whole, what are your overall impressions about the Internship? What stands out for you? Would you recommend the Internship Program to peers?

How satisfied were you with the quality of your overall Internship experience?

1	2	3	4	5
Not at all	A little bit	Somewhat	Quite A Bit	Extremely

FINANCIAL AND ADMINISTRATIVE ASSISTANCE

Financial Assistance

1. Interns receive a full-time salary of \$31,200 for the internship year from July 1 – June 30 inclusive
2. Interns receive full health benefits for the internship year from July 1 - June 30 inclusive
3. Interns have 29 days of paid time off -- vacation, sick days, conference days and personal days for the internship year from July 1 – June 30. They are eligible for maternity leave, family leave, and other forms of leave, under appropriate circumstances.
4. Interns have private offices, equipped with desk, chairs, storage furniture, telephones (with voicemail), and computers (with email, network and internet access), in the Psychiatry Outpatient Departments, which are their home bases. Interns have nearby mailboxes there.
5. Interns have access to shared printers, photocopy machines, and fax machines in the Psychiatry Outpatient Departments, and in the services within which they work.
6. Interns receive Internship Program, Department of Psychiatry, and Mt. Sinai St. Luke's and West Hospitals Handbooks, Orientation Manuals and policies and procedures, in hard copy and online, as well as selected essential books, articles (i.e. in hard copy or online), and audio recorders.

Administrative Assistance

1. Two Education Coordinators provide routine, and as-needed, administrative assistance to all interns. Examples of this are: processing employment documents; facilitating access to email, hospital network, internet and essential online resources; scheduling required employment and training activities; processing time sheets and requests for absence (e.g. for vacation, etc.); providing supplies; distributing paychecks or direct deposit notices; email notification of essential training and administrative activities and information; distribution of mail and training and administrative print materials; and other functions
2. Within the Psychiatry Outpatient Departments, where intern offices are located, the office managers and administrative assistants provide routine, and as-needed, administrative assistance to all interns. Examples of this are: providing supplies and forms; email notification of essential training and administrative activities and information; and distribution of mail and training and administrative print materials. This staff is also responsible for patient appointment scheduling, within an electronic scheduling system, patient registration, and patient billing, within an electronic billing system.
3. Within the clinical services in which interns are working, the office managers and administrative assistants provide routine, and as-needed, administrative assistance to all interns. Examples of this are: providing supplies and forms; email notification of essential training and administrative activities and information; and distribution of training and administrative print materials. This staff is also responsible for patient appointment scheduling, within an electronic scheduling system, patient registration, and patient billing, within an electronic billing system.
4. The Information Technology 'Helpdesk' is available to interns, by email or telephone, on a round-the-clock basis, for consultation and problem-solving.

Workplace Conditions

Office Space and Supplies

The Psychiatry Outpatient Departments (OPDs) serve as the home bases for all interns. Every intern has his/her own office. Each office has a desk, chairs, computer (with email, network and internet connection), telephone (with voicemail), and storage space. To assure personal security, leave the door unlocked, when seeing patients. To assure security of belongings, always lock offices when you leave, and always lock cabinets.

Policies and Procedures for Absence

As state previously are 29 days of 'paid time off' per year – that can be vacation, sick, or personal days.

Vacation Procedure: Vacation will help your quality of life and work! Please use it!

But: there are certain general rules. This is to protect the quality of care of patients, the effectiveness of the training experience at key milestones (i.e. beginning and end of training), and to permit coordination of vacations of the many people (interns, fellows, residents, staff) who are all entitled to vacation.

General Rules:

- Don't take vacation in July or in June.
- Vacation must be requested far in advance using the form below. One month is the minimum advance time. (If there is less advance time, this could result in your request not being allowed unless for emergency reasons). It must be requested from the various Directors who work with you. This means: Rotation Directors; OPC Director; and Training Director. As soon as you know about your desired vacation plans, you'll need to talk to these people and submit the Time Off Request Form. This includes speaking to Rotation Directors you may be working with later in the year. Vacation Request Forms with plans for coverage (i.e. agreed to by those covering you) and signatures of Rotation Directors and the Training Director are required. You'll also need approval from the OPC Director.
- Vacation should be a maximum of 1 work week (plus weekend of course).
- Only take 1 week of vacation per 4-month Rotation period.
- Please remember that you have personal days, sick days, and conference days also.
- Of course, urgent needs for exceptions arise. As with everything that may arise: Please talk to the Training Director as soon as you realize that an exception must be requested.

Sick Days: In the event of illness or unexpected absence, an intern must notify the Director of Training, Education Coordinators, and Supervising Psychologist on all services in which the intern is working. Notification must occur on a daily basis. Or, in the case of a prolonged illness, you may call in, indicate how many days you anticipate missing, and contact this office again on the date of your return. If absent for 3 or more consecutive days, 'fit for duty' clearance from Employee Health Service must be obtained. The intern is responsible for cancelling all patient appointments, and arranging coverage.

Personal Days: The same procedures as for vacation must be followed for use of personal days (and conference days).

TIME OFF REQUEST FORM - DEPARTMENT OF PSYCHIATRY

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER

Name: _____ Date: _____

Division or Department:
 Dates Requested _____

Vacation Check Requested?	Yes	No	TOTAL HOURS	TOTAL DAYS
TYPE OF LEAVE				
Vacation			_____	_____
Personal			_____	_____
Marriage			_____	_____
Maternity /Paternity			_____	_____
Jury Duty*			_____	_____
Other (Conferences, Death in family, etc)			_____	_____

*Jury Duty notification must be submitted to supervisor and/or directors of service so proper coverage may be planned. Upon return, submit official record of attendance.

Coverage provided by:

Approved by (Director of Service): _____

(Director of Discipline Training): _____

Maternity Leave: Interns are eligible for maternity leave, with advance approval. Annual vacation and sick days may be applied toward maternity leave.

Coverage: Whenever an intern is absent, clinical coverage is imperative. Coverage assures that the expected, unexpected or emergency needs of patients can be met in a streamlined fashion. It is the intern's responsibility to arrange coverage, preferably from another intern or another clinician also working with given patient, with the understanding that a licensed person must be listed on the coverage form in the OPD.

Attendance Records: Attendance records for all interns will be maintained on an academic calendar from July through June. In order to assist the Department in maintaining the most accurate attendance records possible, all interns are required to complete a Staff Time Sheet every other Thursday. Time sheets will be emailed to you every other Thursday. Completed forms should be faxed or email to the attention of the Education Coordinators at 523-1685. A time sheet must be submitted, or you will not be paid until the following pay period.

Hospital Holidays: Hospital holidays, when the hospital is closed, include, but are not limited to: New Year's Day; Martin Luther King's Birthday; Presidents Day; Memorial Day; July 4; Labor Day; and Christmas Day. There are other holidays that are observed at either Mt. Sinai St. Luke's or West Hospitals. A full list of

holidays can be found here: http://intranet1.mountsinai.org/humanresources/forms/Holiday_Schedule_2019-SLW.pdf

Paychecks: Paychecks will be issued every other Thursday. Interns can pick up their paychecks from their mailboxes on the 16th floor of the Medical Arts Building located at 1090 Amsterdam (at 114th Street). If you wish, you may make arrangements to have your paycheck deposited directly into your bank account(s).

Benefits: All interns are immediately eligible for a full range of benefits. Information will be provided by the Human Resources Division at Mount Sinai. Benefits at a Glance can be located here: <http://intranet1.mountsinai.org/HumanResources/Benefits/index.asp>

Copy of Jitney Schedule:

A hospital jitney service runs between Mount Sinai St. Luke's and Mount Sinai West at regular intervals. The schedule for this jitney can be found at http://mshsintranet.mountsinai.org/uploadedFiles/CORP/Services/Real_Estate_NEW/SLR%20Shuttle%20Bus%20Schedule.pdf

Communication

Mailboxes: All interns have mailboxes at 1090 Amsterdam Avenue, on the 16th floor and in the Psychiatry Outpatient Departments.

Electronic Communication: All interns have email, network and internet access. Electronic communication is the means through which electronic medical records (on EPIC for the Adult Outpatient Psychiatry Clinic, and Totally Integrated Electronic Record (TIER) for the Center For the Intensive Treatment Of Personality Disorders (CITPD) and the Child and Family Institute (CFI, the Child Outpatient Psychiatry Clinic and Comprehensive Adolescent Rehabilitation and Education Service (CARES) systems) are maintained. These are the systems within which vital clinical information (e.g. intake assessments, progress notes, orders, supervisor attestations, etc.) is created and maintained. Interns also have access public drives, of the hospital network – where non-confidential material (e.g. articles, regulations, forms, etc.) may be stored. We will assist you in getting access to and training for these various electronic medical records.

Telephones: All intern offices have telephones. Outside hospital numbers require dialing a 9 prior to the phone number. In hospital numbers require dialing the last 6 numbers of the phone number. Long distance calls are made through the hospital operator, accessible by dialing 00.

All intern telephones have voicemail. In order to meet potential emergency needs of patients, all voicemail must contain the following answer script: 'You have reached the voicemail of _____. If this is an emergency, please hang up the phone, dial 911, and go to your nearest emergency room. Or, press 2 and you will be connected to the Mt. Sinai St. Luke's Hospital Emergency Room.'

Paging: Inside the hospital, individuals with hospital pagers may be paged by dialing 05, and following the voice prompts, to: enter a 5-digit pager number; and enter your call back number. Outside the hospital, this may be accomplished by dialing 212 523-4000. To obtain pager numbers spontaneously, dial the pager operator at 00.

Fax Machines: Fax machines are available in the Outpatient Psychiatry Departments, Education and Training Administrative Suite, and in every service. Outside hospital numbers require dialing a 9 prior to the phone number. In hospital numbers require dialing the last 6 numbers of the phone number.

Photocopy Machines: Photocopy machines are available in the Outpatient Psychiatry Departments, Education and Training Administrative Suite, and in every service. Some machines have scanning capacity.

Clinical Documentation: Good treatment requires complete and timely documentation. Documentation is a major means through which clinical information may be shared among (current and future) clinicians treating a patient. Documentation is the permanent record of a patient's course in treatment. It is an ethical, legal and regulatory responsibility. Singularly, it provides evidence of delivery of services, for reimbursement.

Most services use a computerized medical record, EPIC or the Totally Integrated Electronic Record (TIER), accessible, respectively, via the EPIC or TIER Workflow icons on your computer desktops. All interns will be trained in the use of EPIC and TIER – via whole-day training (i.e. for EPIC), live demonstration during Orientation (i.e. EPIC and TIER), and viewing of network-accessible video tutorials (i.e. TIER). Staff and Psychology Fellows, with EPIC and TIER experience, are willing, capable guides for EPIC and TIER. The Information Technology Helpdesk at 212 523-6486 is available on a round-the-clock basis for problem-solving and assistance.

Security

Safety and security is a foremost priority of our Program, Department and Hospital. If you have any concern about safety or security, it is essential to tell nearby staff immediately, and to call Security personnel as well. Security personnel are immediately available at 212 523-4444 (Mt. Sinai St. Luke's Hospital) or 212 523-7512 (Mt. Sinai and West Hospitals). If a situation presents imminent risk of harm, it is essential to call Transcare at 718 763-888 for emergency transport. In an office, to assure personal security, leave the door unlocked, when seeing patients. Leaving an office, to assure security of belongings, always lock offices, and always lock cabinets. In the hospital, to assure security, ID badges must be worn, and visible, at all times. Policies and procedures for assuring safety and security are covered in the Psychiatry Outpatient Handbooks (enclosed here).

Standards for Workplace Behavior

Dress Code: Interns are expected to dress neatly and in a professional manner. Men are expected to wear shirt and ties. Women are expected to wear closed-toe shoes. Jeans and sneakers are not considered appropriate professional dress.

The Internship Program is dedicated to developing interns' professional identity, independent professional judgment and functioning, and capacities for collaboration and consultation, within a multidisciplinary hospital setting. The Program is aimed at developing interns' capacities to be skilled, conceptually-based, and empathic clinicians – with a keen sense of the role of ethnic, cultural and contextual factors in individuals' lives.

To these ends, interns are expected to meet the following standards:

1. Maintenance of a professional manner and compliance with APA ethical principles with patients and colleagues;

2. Adherence to hospital wide and departmental policies in regard to attendance, vacation, sick days, etc., including timely submission of time-off requests;
3. Timely completion of charting and all other paperwork; and
4. Primary allocation of professional time, energy, and effort to internship activities throughout the year.

In accord with our institutional Corporate Compliance Plan, interns are expected to meet the following standards:

- Strictly observe all laws and regulatory requirements that apply to his/her activities
- Be familiar with and understand the basic legal and regulatory requirements of psychologists
- Respect the cultural values and religious beliefs of patients and their family members, co-workers, staff members and visitors
- Prevent and/or refrain from discrimination or harassment of any kind
- Keep accurate, timely records
- Protect the confidentiality of patients and all hospital-related information
- Adhere to the highest ethical standards
- Refrain from conflicts of interest

CODES OF CONDUCT

Trainees at the MSSLW internship program are expected to abide by the Mount Sinai Code of conduct on a system-wide level (which can be found here:

https://www.mountsinai.org/files/MSHealth/Assets/HS/About/Compliance/MS_Code_of_Conduct.pdf), as well as adhere to the Ethical Principles of Psychologists and Code of Conduct, which is outlined below. Adherence to the Ethical Principles of Psychologists and Code of Conduct is a primary priority and infused in all aspects of our Program, including being the subject of a focused didactic course and as a fundamental part of all supervisory discussions. The 2002 APA Ethics Code with 2010 and 2016 Amendments is as follows:

INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A – E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development;

social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably*, *appropriate*, *potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

Principle A: Beneficence and Nonmaleficence

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence.

Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

Principle B: Fidelity and Responsibility

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

Principle C: Integrity

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

Principle D: Justice

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists.

Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

Principle E: Respect for People's Rights and Dignity

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. Resolving Ethical Issues

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. Competence

2.01 Boundaries of Competence

- (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
- (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
- (c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

(f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. Human Relations

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard [1.08, Unfair Discrimination Against Complainants and Respondents.](#))

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

(a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

(b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04(a).

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards [3.04, Avoiding Harm](#), and [3.07, Third-Party Requests for Services.](#))

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations

involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards [3.05, Multiple relationships](#), and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards [3.05, Multiple Relationships](#); [6.04, Fees and Financial Arrangements](#); [6.05, Barter with Clients/Patients](#); [7.07, Sexual Relationships with Students and Supervisees](#); [10.05, Sexual Intimacies with Current Therapy Clients/Patients](#); [10.06, Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients](#); [10.07, Therapy with Former Sexual Partners](#); and [10.08, Sexual Intimacies with Former Therapy Clients/Patients](#).)

3.09 Cooperation with Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard [4.05, Disclosures](#).)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards [8.02, Informed Consent to Research](#); [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards [8.02, Informed Consent to Research](#); [9.03, Informed Consent in Assessments](#); and [10.01, Informed Consent to Therapy](#).)

3.11 Psychological Services Delivered to or Through Organizations

(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also

Standard [6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.](#))

4. Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard [2.05, Delegation of Work to Others.](#))

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard [3.10, Informed Consent.](#))

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards [8.03, Informed Consent for Recording Voices and Images in Research](#); [8.05, Dispensing with Informed Consent for Research](#); and [8.07, Deception in Research.](#))

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard [6.04e, Fees and Financial Arrangements.](#))

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard [4.01, Maintaining Confidentiality.](#))

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally

identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. Advertising and Other Public Statements

5.01 Avoidance of False or Deceptive Statements

- (a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.
- (b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.
- (c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

- (a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.
- (b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard [1.01, Misuse of Psychologists' Work](#).)
- (c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, Internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard [2.04, Bases for Scientific and Professional Judgments](#).)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement

appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. Record Keeping and Fees

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard [4.01, Maintaining Confidentiality](#).)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards [4.01, Maintaining Confidentiality](#), and [6.01, Documentation of Professional and Scientific Work and Maintenance of Records](#).)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards [3.12, Interruption of Psychological Services](#), and [10.09, Interruption of Therapy](#).)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards [10.09, Interruption of Therapy](#), and [10.10, Terminating Therapy](#).)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards [4.05, Disclosures](#); [6.03, Withholding Records for Nonpayment](#); and [10.01, Informed Consent to Therapy](#).)

6.05 Barter with Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards [3.05, Multiple Relationships](#), and [6.04, Fees and Financial Arrangements](#).)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or

payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards [4.01, Maintaining Confidentiality](#); [4.04, Minimizing Intrusions on Privacy](#); and [4.05, Disclosures](#).)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard [3.09, Cooperation with Other Professionals](#).)

7. Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard [5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs](#).)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard [5.01, Avoidance of False or Deceptive Statements](#).)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard [2.03, Maintaining Competence](#).)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard [7.02, Descriptions of Education and Training Programs](#).)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard [3.05, Multiple Relationships](#).)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for

providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships with Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships)

8. Research and Publication

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their

financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

- (a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.
- (b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research

- (a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.
- (b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.
- (c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

- (a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.
- (b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.
- (c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

- (a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.
- (b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.
- (c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)

- (d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.
- (e) Psychologists use a procedure subjecting animals to pain, stress, or privation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.
- (f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.
- (g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

- (a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)
- (b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

- (a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)
- (b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.
- (c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

- (a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from

requiring that such individuals or groups be responsible for costs associated with the provision of such information.

(b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. Assessment

9.01 Bases for Assessments

(a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard [2.04, Bases for Scientific and Professional Judgments.](#))

(b) Except as noted in [9.01c](#), psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards [2.01, Boundaries of Competence](#), and [9.06, Interpreting Assessment Results.](#))

(c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

(a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards [2.05, Delegation of Work to Others](#); [4.01, Maintaining Confidentiality](#); [9.01, Bases for Assessments](#); [9.06, Interpreting Assessment Results](#); and [9.07, Assessment by Unqualified Persons](#).)

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard [9.11, Maintaining Test Security](#).)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards [2.01b and c, Boundaries of Competence](#), and [3.01, Unfair Discrimination](#).)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard [2.05, Delegation of Work to Others](#).)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately

describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard [2.01b and c, Boundaries of Competence](#).)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11 Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard [9.04, Release of Test Data](#). Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. Therapy

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard [3.10, Informed Consent](#), psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards [4.02, Discussing the Limits of Confidentiality](#), and [6.04, Fees and Financial Arrangements](#).)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards [2.01e, Boundaries of Competence](#), and [3.10, Informed Consent](#).)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard [4.02, Discussing the Limits of Confidentiality](#).)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard [3.05c, Multiple Relationships.](#))

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies with Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies with Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy with Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies with Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard [3.05, Multiple Relationships.](#))

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard [3.12, Interruption of Psychological Services.](#))

10.10 Terminating Therapy

- (a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
- (b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.
- (c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

ST. LUKE'S/WEST HOSPITAL INTERNSHIP GRIEVANCE PROCEDURES

Following is a definition and explanation of formal grievance procedures in the St. Luke's/West Hospital Internship Program.

Grievances on the part of interns towards the program

1. Grievances are to be distinguished from ongoing difficulties or problems. Difficulties and problems either with personnel or administrative aspects of the internship, or with any other aspect of the training experience, are seen as a normative aspect of the internship. When an intern has a problem, that intern should discuss the issue with a supervisor(s) and/or training director(s). The problem will be discussed from clinical, professional, political, and system points of view. Solutions will be sought first for the intern to implement, and if the problem appears to need it, solutions on the part of supervisors and training directors will be implemented. The entire process will be understood to be a valuable aspect of the intern's learning and training.
2. Grievances are defined as problems with personnel or structural aspects of the internship that are chronic and significantly interfere with the intern's capacity to perform his/her tasks, and that cannot be ameliorated by the processes discussed above. If, an intern thinks that he/she has a grievance that intern should first discuss the problem as a grievance with a training director and then present the grievance in written form to the training director. The training director will then provide a solution, will implement that solution, and will provide the intern with a written account of measures being undertaken to find an acceptable answer. If the intern does not feel that the grievance has been addressed satisfactorily, then the intern can present the grievance to the Director of Psychology Education or another psychology Training Director for consultation. If the intern still does not feel that the problem has been addressed satisfactorily he/she can present the written grievance to the Director of Residency Education. If the internship is unable to address the grievance to the intern's satisfaction, then the intern can consult with the graduate school training director who can in turn, consult with internship authorities.

Grievances on the part of the internship program towards an intern

1. Grievances are to be distinguished from ongoing intern capacities that need to be worked on or strengthened. The identification of areas of strength and weakness is seen as an integral part of the training and an important aspect of the intern's growth in professional

development throughout the year. Areas of weakness are to be identified on an ongoing basis in supervision and worked on, as well as in mid-year evaluations.

Due Process For Problem Behavior Advisement and Remediation, Probation, Termination, and Grievance

Definition of Problem Intern Behaviors

Problem intern behaviors are defined as behaviors or attitudes that seriously disrupt the intern's capacities to: deliver clinical services; maintain working relationships with peers, supervisors or other staff; or adhere to appropriate standards of ethical and professional behavior. Problem intern behaviors are distinguished from weaknesses, which do not produce these serious consequences, which are the focus of ongoing supervision. In fact, identification of areas of strength and weakness is an integral part of training and of the intern's professional development throughout the year. Areas of weakness are to be identified on an ongoing basis in supervision and worked on, throughout the year.

Problem behavior is defined broadly as interference in professional functioning, reflected in one or more of the following ways:

1. Inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
2. Inability to acquire professional skills in order to reach an acceptable level of competency, and/or
3. Inability to control personal psychological dysfunctions, and/or excessive emotional reactions which interfere with professional functioning over an extended period of time.

Problem behavior is characterized by the following features:

1. The quality of services delivered by the intern is sufficiently negatively affected over a significant period of time;
2. The problem is not restricted to one area of professional functioning;
3. The intern persistently does not acknowledge, understand, or address the problem when it is identified;
4. A disproportionate amount of attention by training personnel is required; and/or
5. The problem behavior does not change as a function of feedback, remediation efforts, and/or time.

Advisement of Problem Behaviors, Remediation, Probation,

When, through the Intern Evaluation and Feedback Procedures described in Intern Evaluation and Feedback Procedures (in this Handbook), intern problem behavior, having the above characteristics is identified, a series of procedures for further response is initiated. These include:

1. The Training Committee will review the negative evaluations obtained, and determine the appropriate course of action;
2. The intern will be advised, in writing, of this review, and invited to provide any statement or information;
3. With all information in hand, the Training Committee will take one or more of the following actions:
 - a. The Committee may determine that no further action, other than existing supervision, monitoring, evaluation, and feedback; or
 - b. The Committee may produce an Acknowledgment Notice, to the intern, stating:
 - i. It is concerned about the problem behavior, that the intern has been advised of the problem behavior, and that a plan for remediation, with a specific time frame, has been initiated – which could include interventions such as enhanced supervision, with the same or other supervisors, and/or other appropriate interventions. The time frame for review of the problem behavior will be 3 months, or, if first, the next regularly planned evaluation; or
 - ii. It is concerned about the problem behavior, that the intern has been advised of the problem behavior, but that no further action, other than existing supervision, monitoring, evaluation, and feedback, is needed; or
 - c. The Committee may compose and give a Probation Notice to the intern. Probation is intended as a remediation-oriented, time-limited action, in which to assess the intern's continuing ability to complete the internship. At the end of Probation, the Training Committee will be able to determine that the intern: (1) will be able to return to more fully effective functioning; or (2) will not be able to do so. The Probation Notice will include:
 - i. A description of the problem behavior;
 - ii. A plan for remediation – which could include interventions such as: enhanced supervision, with the same or other supervisors; change in the approach and/or emphasis of the supervision; recommendation for personal therapy; recommendation for leave of absence and/or second internship; and/or other intervention(s);
 - iii. A time frame for probation, during which problem amelioration is expected. A reasonable time frame for review of the problem behavior, and the Probation, will have been determined by the Training Committee, and specified in the Probation Notice; and
 - iv. Procedures for assessment of whether or not the problem has been appropriately rectified.
4. Following Acknowledgment or Probation Notice, the following action steps will be taken:
 - a. The Training Director and the intern will review the remediation plan and time frame. The intern may decide either to accept the plan, or to challenge it;
 - b. The Training Director will notify the intern's home doctoral program, in writing, of the intern's problem behavior, Probation status, and the plan and time frame for remediation. If Probation

has the potential to interfere with the intern's accrual of sufficient training hours for completion of internship, the intern, and his/her home doctoral program will be advised of this, in writing. A copy of this notification will be given to the intern.

5. At the specified time point for evaluation of Probation status, the Training Committee will review the problem behavior, and Probation status. If the remediation plan has not rectified the problem behavior, and/or the intern seems unable or unwilling to improve his/her problem behavior, the Training Committee will take one or more of the following actions:

- a. The Training Committee will extend Probation status, under the same conditions, for a specific time period, and notify the intern of this, in writing; or
- b. The Training Committee will extend Probation status, while suspending the intern from professional activities compromised by the problem behavior, for a specific, reasonable, time period -- in which evidence that the problem behavior is rectified could be obtained. Suspension of professional activities will only occur when the determination that the welfare of the intern's could be jeopardized. The Training Committee will notify the intern of this, in writing. If Suspension has the potential to interfere with the intern's accrual of sufficient training hours for completion of internship, the intern, and his/her home doctoral program will be advised of this, in writing. At the end of the suspension period, the Training Committee will review the problem behavior and the indications for suspension, and determine if, and when, the professional activities could be resumed; or
- c. The Training Committee will extend Probation status, while placing the intern on Administrative Leave, and withdrawing all responsibilities and privileges in the institution. Administrative Leave will only be recommended in the event of the intern's: severe violations of the APA Code of Ethics: imminent risk of physical or psychological harm to a patient; or inability to complete the internship, due to severe physical or mental illness. The Training Committee will notify the intern, and his/her home doctoral program, of this, and its effects on stipend, benefits, and accrual of sufficient hours for completion of internship, in writing. If Administrative Leave has the potential to interfere with the intern's accrual of sufficient training hours for completion of internship, the intern, and his/her home doctoral program will be advised of this, in writing; or
- d. The Training Committee will recommend to the Chair, Department of Psychiatry, that the intern be terminated immediately from the internship program. With the Chair's approval, actions for termination will be initiated. Termination will only be recommended in the event of the intern's: severe violations of the APA Code of Ethics: imminent risk of physical or psychological harm to a patient; or inability to complete the internship, due to severe physical or mental illness. Termination will be recommended only after all specified remediation interventions do not rectify the problem behavior, after reasonable time periods. The intern, as well as his/her home doctoral program, will be notified, in writing, of this. If appropriate, the Training Committee will recommend that the intern consider alternatives to his/her original career goals;

6. At end of training year, for interns on active Probation status, the Training Committee will review the problem behavior and Probation status, to determine whether or not the conditions for revoking

Probation status have been met. If the Training Committee determines that problem behavior has not been rectified, and the intern has, thus, not fulfilled program requirements for internship completion, the intern will not be advised, in writing, that he/she has not completed the internship. This will only be recommended in the event of the intern's: severe violations of the APA Code of Ethics: imminent risk of physical or psychological harm to a patient; or inability to complete the internship, due to severe physical or mental illness. It will be recommended only after all specified remediation interventions do not rectify the problem behavior, after reasonable time periods. The intern, as well as his/her home doctoral program, will be notified, in writing, of this. If appropriate, the Training Committee will recommend that the intern consider alternatives to his/her original career goals.

Grievance

At any point in the Evaluation and Feedback, Advisement, Remediation, Probation and Termination process, an intern can initiate the grievance process to challenge an action. The intern has a 5-day window within which to notify the Training Director, in writing, of his/her intent to make this challenge. After this, the intern has a 5-day window within which to provide written explanation of his/her challenge.

With the intern's written grievance in hand, the Training Director convenes an ad-hoc Review Panel to consider the grievance. The Review Panel is composed of 3 staff members, chosen by the Training Director, in consultation with the intern. The Review Panel considers the challenge and its evidence, and makes a decision, by majority opinion. Within 10 days of hearing, the Review Panel prepares a written report of its decision and recommendations, to the intern, and the Chair, Department of Psychiatry.

With the Review Panel's written decision in hand, the intern has a 5-day window, within which to submit a written challenge of the decision and request for further review, to the Chair, Department of Psychiatry and Behavioral Health. The request must explain the grievance, the perceived violation, misinterpretation or misapplication of policies, rules or regulations committed, and the resolution being sought.

With the intern's written challenge, and all previous documents, in hand, the Chair has a 10-day window, within which to consider the challenge, and to prepare a written decision about a course of action. This decision could include: acceptance of Review Panel decision and recommendations; rejection of Review Panel decision and recommendations and provision of alternative decision and recommendations; or re-referral to the Review Panel for further consideration.

Within a 10-day window, the Review Panel will prepare and submit further decisions and recommendations to the Chair.

Considering these, the Chair provides a final decision and recommendations.

With the Chair's final decision and recommendations in hand, the intern has a window of 3 days, within which to submit a written grievance to the Human Resources Department.

With the intern's grievance in hand, the Human Resources Department will conduct a review, make a final decision, and determine appropriate remedy, if needed.

The intern, Training Director, Chair, Department of Psychiatry, the intern's home doctoral program, and other appropriate parties will be notified, in writing, of the final decision, determined by Human Resources review.

NON-DISCRIMINATION AND HARRASSMENT POLICIES

Adherence to The Health Insurance Portability And Accountability Act And Procedures To Protect Privacy

Protection of confidentiality is also a priority concern in our Program, Department and Hospital. At admission, and at any other time during the course of treatment when it is needed, HIPAA authorization, consent, and consent for release of information is requested of patients. It will be a part of the above-mentioned focused course on ethical principles and conduct. The exact procedures used are discussed in detail in the attached Outpatient Psychiatry Department Handbook.

Our Commitment

Mt. Sinai St. Luke's and West Hospitals is an equal opportunity employer. In accord with New York City, New York State and U.S. Government law, discrimination on the basis of age, gender, race/ethnicity, veteran status, religion, marital status, disability, sexual orientation or pregnancy is forbidden. Mt. Sinai St. Luke's and West Hospital Psychology Internship Program is accredited by the APA Commission On Accreditation through 2019, and abides by all rules and regulations of accreditation. Mt. Sinai St. Luke's and West Hospital Psychology Internship Program abides by all APPIC rules governing the application and selection process.

The program recognizes the importance of cultural and individual differences and diversity in the training of psychologists. The Commission on Accreditation defines cultural and individual differences and diversity as including, but not limited to, age, disability, ethnicity, gender, gender identity, language, national origin, race, religion, culture, sexual orientation, and socioeconomic status. The program has made systematic, coherent, and long-term efforts to attract and retain interns and faculty/staff from diverse backgrounds into the program. Consistent with such efforts, it acts to ensure a supportive and encouraging learning environment appropriate for the training of individuals are diverse and the provision of training opportunities for a broad spectrum of individuals. Further, the program avoids any actions that would restrict program access on grounds that are irrelevant to success in graduate training, either directly or by imposing significant and disproportionate burdens on the basis of the personal and demographic characteristics set forth in the definition of cultural diversity. Because of the United States' rich diverse higher education landscape, training can take place in both secular and faith-based settings. Thus this requirement does not exclude programs from having a religious affiliation or purpose and adopting and applying admission and employment policies that directly relate to this affiliation or purpose, so long as public notice of these policies has been made to applicants, interns, faculty, and staff before their application or affiliation with the program. These policies may provide a preference for persons adhering to the religious purpose or affiliation of the program, but they shall not be used to preclude the admission, hiring, or retention of individuals

because of the personal and demographic characteristics set forth under the definition of cultural diversity. This provision is intended to permit religious policies as to admission, retention, and employment only to the extent that they are protected by the U.S. Constitution. This provision will be administered as if the U.S. Constitution governed its application. Notwithstanding the above, and regardless of a program's setting, the program may not constrain academic freedom or otherwise alter the requirements of these standards. Finally, compelling pedagogical interests require that each program prepare interns to navigate cultural and individual differences in research and practice, including those that may produce value conflicts or other tensions arising from the intersection of different areas of diversity.

The Mount Sinai Health System complies with applicable Federal civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, religion, disability, sex, sexual orientation, gender identity, or gender expression.

The Mount Sinai Health System provides: Free aids and services to people with disabilities to communicate effectively, such as: Qualified sign language interpreters Written information in other formats (large print, audio, accessible electronic formats, other formats)

Free language services to people whose primary language is not English, such as: Qualified interpreters Information written in other languages

If you need these services, please contact your provider ahead of time, when possible.

If you believe that the Mount Sinai Health System has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, sex, sexual orientation, gender identity, or gender expression, you can file a grievance at:

The Mount Sinai Hospital Patient Service Center One Gustave L. Levy Place, Box 1515 New York, NY 10029 Telephone: 212-659-8990 Fax: 212-241-7994

1/29/2019 Nondiscrimination Notice | Mount Sinai - New York

<https://www.mountsinai.org/nondiscrimination-notice> 2/5

Mount Sinai St. Luke's Office of Patient Relations 1111 Amsterdam Ave New York, NY 10025 Telephone: 212-523-3700

Mount Sinai West Office of Patient Relations 1000 Tenth Ave New York, NY 10019 Telephone: 212-523-7225

If you need help filing a grievance, a Patient Representative is available to help you.

1/29/2019 Nondiscrimination Notice | Mount Sinai - New York

<https://www.mountsinai.org/nondiscrimination-notice> 3/5

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> (<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>), or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html> (<http://www.hhs.gov/ocr/office/file/index.html>).

DIVERISTY AND INCLUSION RESOURCES

The Department of Psychiatry, The Icahn School of Medicine and the overall Mount Sinai Health System in which are program is imbedded are committed to multicultural diversity in faculty, staff, patients and trainees. In fact, in 2017, the Mount Sinai Health System was ranked number 1 on the Diversity Inc's national "Top Hospitals and Health Systems' list. These governing institutions as well as our training program uphold non-discrimination policies aimed at providing a work place and community that is respectful of people of diverse ages, disabilities, ethnicities, genders, gender identities, languages, national original, race, religion, culture, sexual orientation and socioeconomic status.

As a training program we demonstrate our commitment to multicultural awareness in the following ways:

- 1.) We recruit and aim to retain diverse faculty.
- 2.) We recruit intern applicants with cultural and individual differences and diversity as defined by the Commission on Accreditation.
 - a.) We try to ensure that the pool of applicants we interview are diverse in age, ethnicity, gender, gender identity, sexual preference, national origin, race, culture and location of graduate program.
 - b.) We stress our commitment to multicultural competence on our interview days and during our program orientation in July.
- 3.) In our final APPIC rankings to the National Match, we do not discriminate based on any of the above delineated diversity/culturally- related factors. The program has nondiscriminatory policies and operating conditions and avoids any actions that would restrict program access on grounds that are irrelevant to success in an internship or the profession.
- 4.) We strive to create a supportive training environment where issues of diversity amongst our trainees can be openly discussed and explored. This is true of our formal process group as well.
- 5.) Relevant to multicultural/diversity training, our formal didactics include:
 - a.) A monthly diversity case conference for both the adult and child track interns led by Shilpa Taufique, Ph.D., who is the Chief Psychology at MSSLW, and

b.) A diversity workshop for our adult and child interns led by Emmett McCaskill, Ph.D. (an Assistant Professor of Psychology at Barnard University) wherein direct discussion amongst interns about multicultural diversity is encouraged.

6.) Our supervisors are given in-service training on multicultural awareness and are encouraged to have this awareness infuse all aspects of their work with trainees.

7.) In meetings with the Directors of Training, trainees are encouraged to inform us as to ways the system can improve in terms of its cultural attunement. A strong effort is made to implement these changes.

8.) We have internally created a Multicultural Awareness Advisory Committee (MAAC) which is led by Dr. Daniel Gaztambide who is a member of our voluntary faculty and Dr. Joseph Ruggiero who is a member of our permanent faculty. Dr. Gaztambide teaches courses on multicultural issues at both City College and Rutgers University and is the 2014 recipient of the APA Division of Psychoanalysis Multicultural Scholarship Award. He was also nominated by our department for the APA award in diversity training. Dr. Ruggiero has recently published on LGBTQ issues as related to treatment and training. There are currently ten other members of the faculty who sit on this committee including our Associate Directors of Training. The MAAC is available to all faculty and trainees to consult/advise as to the management of issues related diversity and multicultural sensitivities.

The program does not adhere to a religious affiliation or purpose that impacts its admission and/or employment policies.

Mount Sinai Health System Office for Diversity and Inclusion (ODI) “is a System-wide entity charged to support the Mount Sinai Health System (MSHS) in embracing the principles of diversity and inclusion as key drivers for excellence and innovation for unrivaled healthcare service delivery, medical and health education, and research. Our mission is one which champions a diverse workforce, strives to create a multicultural environment, and fosters an inclusive setting to ensure delivery of high-level care to the diverse patient populations in New York City and beyond.” The ODI website has numerous resources related to initiatives and programs in many domains, including resource groups for faculty, staff or students seeking opportunities for support or workplace diversity development. More information can be found at: <http://www.mountsinaihealth.org/about-the-health-system/diversity>

DISABILITY POLICIES

MSSLW internship abides by the Icahn School of medicine Disability policies which is as follows:

ICAHN SCHOOL OF MEDICINE AT MOUNT SINAI DISABILITY SERVICES

Disability is defined by the Americans with Disabilities Act of 1990 as "a physical or mental impairment that substantially limits one or more major life activities." An individual may also qualify as disabled if he/she has had impairment in the past or is seen as disabled based on a personal or group standard or norm. Such impairments may include physical, sensory, and cognitive or intellectual impairments. Mental disorders (also known as psychiatric or psychosocial disability) and various types of chronic disease may also be considered qualifying disabilities. A disability may occur during a person's lifetime or may be present from birth.

The Icahn School of Medicine at Mount Sinai's (which includes the School of Medicine and Graduate School of Biological Sciences) Student Disability Services (SDS) are dedicated to providing equal educational opportunities for students with physical, learning and psychiatric disabilities. The Icahn School of Medicine recognizes its obligations under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, as amended. The policy of the school is that no qualified student with a disability will be excluded, denied participation or subjected to discrimination from any program or activity.

The Disability Officer (DO) manages all curricular, academic and student affairs-related aspects of the student's needs by working with faculty and administrators to provide services to students with disabilities. The role of the DO is to assist students in obtaining the services and accommodations required to ensure equal access to all aspects of the student experience and to assist the school in meeting its compliance obligations. The DO is the only person authorized to determine accommodations to students on behalf of The Icahn School of Medicine. The DO will consult with a member of the appeals committee when an accommodation may not be feasible or appropriate for a specific course or program requirement or in the event that the accommodation would result in a fundamental alteration of an essential aspect of the student's program. Decisions regarding accommodations are made through an interactive process with the DO and the student, and may involve faculty, clerkship directors, members of the appeal committee and outside experts from student health or student mental health services as needed.

Appropriate accommodations are determined following an individualized assessment of each request and discussion with the Disability Officer. The following factors are considered in determining appropriate accommodations:

The nature and functional impact of the student's disability; History of accommodations; The necessity of the requested accommodations and possible alternative accommodations; Whether the requested accommodations will alter the essential requirements of the course or program.

Students seeking accommodations or support services at Icahn School of Medicine are required to register with Student Disability Services through the DO. Accommodations will not be granted until the student has completed the registration process and accommodations once approved are not retroactive. The general registration process is as follows:

Contact SDS

Current and prospective students should call (212) 241-4785 or email the DO, Christine Low, (christine.low@mountsinai.org) to schedule an intake appointment. Appointments can take

place via phone or in person. This information is found on the website, and students are notified about Student Disability Services at the time of admittance, and during the pre-matriculation process.

Provide documentation of your disability

Students are encouraged to send their disability documentation to the DO in advance of their intake appointment, but can also bring documentation to the appointment. The supporting documentation must:

- be current (within the past 3 years);
- be in the form of a letter from an appropriately credentialed professional, physician and/or school;
- include medical information that describes the limitations of the disability;
- include evaluation/diagnostic test results used to make the diagnosis;
- indicate the requested accommodation with an explanation of its relevance to the disability.

Students are encouraged to provide whatever documentation they have for evaluation. The School also maintains the option of seeking a second, professional opinion regarding documentation presented to verify disabilities. Documentation accepted by the DO is valid as long as a student is continuously enrolled at the School. However, if there is a break in the student's enrollment, s/he may need to present updated documentation to the DO in order to receive disability services. The application, supporting documentation and information from verbal discussions with the student will be kept on file with the DO. In accordance with FERPA, information from the file will only be shared with other institutional personnel when there is a legitimate educational need to know. Documentation is saved for six years after student leaves the school. The student is responsible for any costs or fees associated with obtaining the necessary documentation to support his/her claim. Students who do not have documentation of their condition, and/or who believe they have an undiagnosed condition, should contact the DO to discuss their circumstances further.

Make a formal request for accommodations

Students must complete the request for accommodations form-Disability Services and Request for Accommodations Form:

Accommodation Request Form (this form is located on the ISMMS website)

Students are encouraged to submit the completed form to the DO in advance of the intake appointment, but can bring the completed form to the intake appointment, or complete it during or after the meeting.

Determine eligibility and accommodations

The DO will review requests for accommodations, taking into consideration the information provided during the intake meeting with the student, submitted disability documentation, and the

requirements of the academic program to determine eligibility for services and, if appropriate, recommend specific accommodations.

Accessing recommended accommodations

Students found eligible for accommodations, are required to meet with the DO provider to obtain an accommodation letter and review the policies and procedures regarding the provision of accommodations at Icahn. After receiving a letter of approved accommodations the student must schedule a time to meet with instructors to deliver the accommodation letter and discuss granted accommodations. Students are responsible for notifying the DO immediately if there are any problems receiving accommodations, or if a student feels s/he have been discriminated against or treated differently in any way. Students are required to meet with the DO annually to review accommodations.

Disability Appeals Procedure

Applicability

The appeals procedure set forth below is designed to address disputes concerning the following:

1. Disagreements regarding a requested service, accommodation, or modification of an Icahn School of Medicine practice or requirement;
2. Inaccessibility of a program or activity.

Appeals Committee The Icahn School of Medicine's Appeals Committee is responsible for administering the appeals procedure. The Appeals Committee has six voting members; the Director of Enrollment Services, two members from the Medical School-appointed by the Dean, two members from the Graduate School appointed by the Dean; as well as the DO. Additional members from student health or student mental health may be asked to participate in the review of cases requiring specialized knowledge as needed. Disability-related law and Icahn policy prohibit retaliation in any form against persons who file complaints.

Informal Resolution Prior to initiating the formal appeals procedure set forth below, the student should, in general, first discuss the matter orally or in writing with the DO. When the DO is notified that a student's approved accommodations have not been provided by the onsite instructor the DO is required to notify the Dean. If no resolution results, or if direct contact with the DO is inappropriate under the circumstances, the student should initiate an appeal.

Appeals: Appeals must be filed as soon as possible, but in no event later than 10 days after the end of the semester

in which the concern arose. Appeals must be filed in writing and include the following:

- a. The grievant's name, address, email address and phone number;
- b. A full description of the problem;
- c. A description of what efforts have been made to resolve the issue informally;

d. A statement of the remedy requested.

The appeal should be submitted to Director of Enrollment Services.

The Appeals Committee, will review the provided information, supporting documentation from the student's file and meet with the student. It may be necessary to gather additional documentation, speak with faculty, clerkship directors or speak with a student's services provider.

Findings Upon completion of the review, the DO will prepare and transmit to the student a final report containing a summary of the investigation, written findings, and a proposed disposition. This report will be expected within 60 calendar days of the filing of the appeal. The deadline may be extended by the DO for good cause.

Final disposition The disposition proposed by the Appeals Committee will be put into effect with deliberate speed.

Students may also seek resolution through the Office of Civil Rights of the Federal Department of Education Online: www.ed.gov/about/offices/list/ocr/complaintintro.html. E-mail: ocr@ed.gov

Assistance Animals Information and Agreement Form

The Icahn School of Medicine at Mount Sinai ("Mount Sinai" or the "School") recognizes the importance of "Service Animals" as defined by the Americans with Disabilities Act Amendments Act ("ADAAA") and the broader category of "Assistance Animals" under the Fair Housing Act ("FHA") that provide physical and/or emotional support to individuals with disabilities. The School is committed to allowing individuals with disabilities the use of a Service Animal on campus to facilitate their full participation and equal access to the School's programs and activities. The School is also committed to allowing Assistance Animals that are necessary to provide individuals with disabilities and equal opportunity to use and enjoy Mount Sinai housing unless doing so would pose an undue administrative or financial hardship.

This Policy explains the specific requirements applicable to an individual's use of an Assistance Animal in Mount Sinai housing. The School reserves the right to amend this Policy as circumstances require. This policy applies solely to Assistance Animals as defined by the FHA that may be necessary in Mount Sinai housing. It does not apply to Service Animals as defined by the ADAAA.

The School will not retaliate against any person because that individual has requested or received a reasonable accommodation in Mount Sinai housing, including a request for an Assistance Animal.

Definition of Assistance Animal

Assistance Animals ("AA") are a category of animals that may work, provide assistance, or perform physical tasks for an individual with a disability and/or provide necessary emotional

support to an individual with a mental or psychiatric disability that alleviates one or more identified symptoms of an individual's disability, but that are not considered Service Animals under the ADA. Some AAs are professionally trained, but in other cases AAs provide the necessary support to individuals with disabilities without any formal training or certification.

The question in determining if an AA will be allowed in Mount Sinai housing is whether or not the AA is necessary because of the individual's disability to afford the individual an equal opportunity to use and enjoy Mount Sinai housing and whether its presence in Mount Sinai housing is reasonable and would not pose an undue administrative or financial burden. The request may also be denied if the specific AA in question (1) poses a direct threat to the health or safety of others that cannot be reduced or eliminated by another reasonable accommodation or (2) would cause substantial physical damage to others. However, even if the individual with a disability establishes necessity for an AA and it is allowed in Mount Sinai housing, an AA is not permitted in other areas of the School (e.g. academic facilities, labs, dining facilities, libraries, etc.).

The School will not limit housing assignments for individuals with AAs to any particular building or buildings based on an individual's need for an AA because of a disability. However, the School reserves the right to assign an individual with as appropriate to ensure that the presence of AAs is not an undue administrative burden or fundamental alteration of Mount Sinai housing.

Removal of Assistance Animal

The School may require the removal of an AA from Mount Sinai housing if:

- 1) the animal poses a direct threat to the health or safety of others;
- 2) the animal is not housebroken or is unable to live with others in a reasonable manner, including causing damage to the property of others;
- 3) the animal causes or has caused excessive damage to Mount Sinai housing beyond reasonable wear and tear;
- 4) the owner does not comply with the owner's responsibilities set forth below; or
- 5) the animal or its presence creates an unmanageable disturbance or interference with the School community.

The School will base such determinations upon the consideration of the behavior of the particular animal at issue, and not on speculation or fear about the harm or damages an animal may cause. Should the AA be removed from the premises for any reason, the owner is expected to fulfill his/her housing obligations for the remainder of the housing contract.

Owner's Responsibilities for Assistance Animal

I have been approved to have an AA in my Mount Sinai housing and agree to abide by the following requirements as it relates to my AA.

I will:

1) Comply with local ordinances and state laws governing my AA. This includes but is not limited to, maintaining all required identification tags, licensing, and vaccinations and keeping such records current. I will be responsible for ensuring that all standard vaccinations are completed and documented and the documentation is provided to the school. In addition, documentation that indicates that the AA has been examined by a veterinarian and that it doesn't have communicable diseases, fleas or parasites will be obtained and will be provided to the School. This documentation will be provided prior to moving into Mount Sinai housing with the AA. In addition, I will ensure that my AA continues to have the needed vaccinations, preventive medicines, and examinations, and that this information will be provided annually to the school in for as long as I reside in Mount Sinai housing with the AA. 2) Appropriately care for and supervise the AA (including, but not limited to, providing the necessary food, water, shelter, exercise). I will not abuse, mistreat or neglect the AA, or allow others to abuse or mistreat the AA. Any evidence of mistreatment, abuse, or neglect may result in immediate removal of the AA and/or discipline for the responsible individual. School personnel shall not be required to provide care or food for the AA including, but not limited to, removing the animal during an emergency evacuation such as a fire alarm. Emergency personnel will determine whether to remove the animal and may not be held responsible for the care, injury to, or loss of the animal. 3) Clean up and dispose of all waste (both indoors and outdoors) in a timely and effective method as indicated by the School and, when provided, must use animal relief areas designated by the School. 4) Not leave the AA alone or unattended for an extended period of time. In most cases, the AA should not be left for more than 12 hours.

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5) Kennel, crate, cage, or secure the tank of the animal (as appropriate, based on the type of animal and the animal's size and needs) when unattended. 6) Not allow the AA to disturb, annoy or cause any nuisance to other members of the community. I will prevent odors, noise, damage or other disruptive conduct that disturbs members of the community or damages the premises. 7) Use the most direct entry and exit route to and from my room/floor when entering or exiting the building with my AA. I will keep my AA properly restrained (e.g. on a harness or leash not extended more than 4 feet in length or in an appropriate carrier) when entering and exiting my room. I will not allow my AA to be in any other residence hall room, bathroom, laundry facility, indoor recreational room, computer lab, study room, floor lounge, hallway or other public area. I will not take my AA inside any other building on campus. 8) Prevent the AA from interfering with routine activities of the residence hall or from causing difficulties for students who reside in the building and be sensitive and accommodating to individuals with allergies and/or fear of animals. 9) Be financially responsible for any additional cleaning that is needed or damage that occurs as a result of having an AA in housing (beyond any reasonable wear and tear). This could include, but is not limited to, replacement of furniture, mattresses, flooring (including carpeting), windows, window treatments, screens, and wall coverings. I will be financially responsible for the removal fee incurred if the School deems it appropriate to remove my AA from housing. 10)

Notify the Director of Disability Services if the AA is no longer required and/or present in housing and/or re-submit documentation to that office if I seek to have a different AA. 11) Abide by all other School policies regarding student housing. 12) Provide the name and contact information of someone local who is available to be contacted 24/7 in the case of an emergency to care for my AA. This emergency contact may not be another student residing in school housing except with prior written approval of the School. Note: If the emergency contact is a student that student must comply with all housing policies including restrictions on pets. 13) Fulfill all obligations to my housing contract for the remainder of the contract, even if my AA is removed. 14) When relevant, specifically discuss and set boundaries regarding the AA with any roommate(s), suitemate(s), and/or floor mates. This includes notifying and gaining permission from roommates in the event that someone else will be called on to pick up and remove the animal to care for it. 15) Consent to the inspection of my student residence for fleas, ticks, or other pests as needed. Any inspections will be scheduled in advance by property management. If fleas, ticks, or pests are detected, the residence will be fumigated through approved methods by property management or an outsourced pest control service. If pest treatment is needed, I am financially responsible. If the problem is ongoing or reoccurring, I understand that my housing agreement may be terminated and/or the AA removed. I will also take my AA for examination and treatment by a veterinarian for fleas, ticks or other pests and provide documentation that either none exist or any issue has been fully and successfully treated.

By signing this form I understand the School:

1) Assumes no responsibility for the care and supervision of the AA. 2) Retains the right to inspect the student residence of the AA and/or the AA when deemed prudent and determine if the AA should be removed.

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3) Will remove the AA within 48 hours if it poses a direct threat to the health and safety of persons in student housing or causes physical damage to the property. The student will be billed for any costs associated with the removal of the AA and/or damage caused by the AA. 4) Will consider a release from the housing contract only if the student follows the contract release request procedures.

By signing this form I further agree to the release of information to any potential roommate(s), suitemate(s), floor mates, or others who may be impacted by the AA regarding the presence of the AA and basic information about the animal. Such information shall not include information related to the nature of your disability.

Student signature: _____ Date: _____

The following information must be provided:

Animal's Name _____ Type of animal:

Breed: _____ Coloring/Markings:

Age: _____ Weight: _____ Gender: _____ Spay/Neuter: yes no

License #: _____

_____ Vaccination verified. Date of vaccinations:

_____ Veterinarian exam verified. Date of exam: _____

Emergency contact person:

Name: _____

Phone Number(s): _____

Email Address: _____

Postal Address: _____

MAINTENANCE OF RECORDS

Interns' records are stored in individual charts arranged by training year contained in locked file cabinets in the Psychology Training suite. These locked files include: a copy of application materials, all performance records obtained during their training year, redacted testing reports, formal complaints (if any), and materials submitted on behalf of the trainee by our department for licensure. Records pertaining to interns' training evaluations are permanently maintained. In addition, excel spread sheets and associated graphs are maintained on the progress of each student in each training domain across the training year.

Appendix A

Inpatient Unit 7G: **Handbook:**

Program Description (i.e. type of unit, treatment approaches, intake and evaluation procedures, emergency procedures, discharge procedures, etc.):

The Unit (7G) is a 32 bed general psychiatric inpatient Unit that admits patients from the Emergency Room on a Voluntary or Involuntary (2PC) basis. The average length of stay is approximately two weeks. Patients are assigned to staff as they are admitted by the Chief Resident on the Unit to one of three teams; the Psychology Intern is attached to one team and has a caseload of up to four patients at any one time, all of whom are supervised closely by the Supervising Psychologist (Dr. Michael Roberts). Each Team has a Psychiatrist and Social Worker as well as an Occupational Therapist, Nursing Staff and Nursing Attendants. The Supervising Psychologist is attached to the Team on which the Psychology Intern works. When first assigned a patient the Team will convene and the Psychology Intern will conduct the initial evaluation with the rest of the team in attendance. All members of the team will have some input but it is the responsibility of the intern to collate the information and fill out the eight page Psychiatric Evaluation Form in the chart. Of course, the Supervising Psychologist, as well as other members of the team will provide supervision. After the initial evaluation the Psychology Intern will continue to meet with the patient daily, sometimes with the Supervising Psychologist or other team members present, and the intern will be responsible for providing clinical updates on the mental status of the patient at all of the three Unit Rounds (Mon, Wed, and Friday) during the week, as well as informally on a daily basis to other team members.

Location, Hours, Program Contact Information (i.e. for clients, for staff):

The Unit is located at the Roosevelt site of St. Lukes/Roosevelt Hospital Center, main entrance to hospital on 10th Avenue between 58th and 59th Street. Unit 7G is located in the main building and is a locked Unit. It is critical than when entering or leaving the Unit nobody is admitted or allowed to leave without hospital identification. All staff must wear hospital ID at all times. The hours for the Psychology Intern are 8AM until 12PM. The Supervising Psychologist can be reached at any time by cell phone (917 270 7569), or e-mail at MRJB@att.net. It is expected that the Intern will carry a cell phone (web enabled) at all times and respond immediately if called or e-mailed regarding patient care; there are to be no exceptions to this rule. The phone number of the Nursing Station on the Unit is 212 523 8517 and the intern will be expected to inform the Charge Nurse, or other staff if any important clinical information is to be relayed after normal working hours. Of course, the Intern will also be responsible for updating the Attending Psychiatrist on the Team of any changes in mental status regarding the patient.

Client Population (Eligibility, Diagnostic/Clinical Characteristics Demographics): **Program Organization (i.e. Staffing):**

The patient population on Unit 7G is very diverse, and the length of stay varies from several days to a few weeks. The Intern will be responsible for establishing a therapeutic alliance with patients from many different cultural and national backgrounds. Also, patients vary greatly in terms of diagnosis. While the majority have an Axis 1 diagnosis there is a large co-morbidity with Axis 11 and substance abuse diagnoses within the patient population and the intern will be expected to familiarize himself/herself with the attendant issues. Naturally, the intern must be sensitive to socioeconomic and cultural issues as they bear upon diagnostic considerations, and

will discuss the above in an ongoing fashion with the Supervising Psychologist in supervision. The Unit is very richly staffed with three Attending Psychiatrists, a part-time Supervising Psychologist, two Social Workers, two Occupational Therapists, and Nurses as well as Skilled Nursing Attendants. In addition, at any one time, there are Medical Students, Psychiatric Residents, and one or two Psychology Interns, as well as occasional Nursing Students. As such, each patient will have contact with multiple staff members, both permanent staff as well as trainees, but one clinician is always identified as the "primary" for a patient, be it a Psychology Intern, Psychiatric Resident, or permanent staff member. The Unit Chief, and also head of one of the three clinical Teams, is Dr. Ellen Tabor who is responsible for administrative, supervisory, and other matters on the Unit.

Psychology Intern Role and Responsibilities (including individual therapy, group therapy, family therapy, assessment, intakes, case management, crisis intervention, community meetings, etc; number of patients and groups, days and hours, etc.):

The Psychology Intern, as stated above, will at any time carry up to four cases for which he or she will be the primary clinician. Those cases will belong to the Team headed by Dr. Zainab Hasan (Attending Psychiatrist) and will be followed closely by the intern in conjunction with the Supervising Psychologist, as well as other Team members. After the extended initial evaluation (with all Team members in attendance) the Intern will be responsible for daily encounters with the patient, as well as multiple other contacts on an "as needed" basis to address the patient's ongoing clinical management, and progress on the Unit. The Intern will be responsible for familiarizing himself/herself with the medications that the patient is taking, and for maintaining an ongoing dialogue with the Attending Psychiatrist about how the patient is responding, as well as being alert to possible side effects of the medications. The Intern will also co-ordinate with the Social Worker to reach out to, engage, and maintain contact with family members and significant others, as well as set up and direct family meetings during the patient's stay on the Unit. The Intern will also co-ordinate disposition issues with the Social Worker, beginning with the initial evaluation, as for some patients the length of stay is quite short and consideration must be given to a full disposition from the outset.

Rounds are held three times a week (Monday at 10; Wednesday at 9.30; and Friday at 10) with all staff present to discuss treatment and disposition issues for all patients. The Intern will be expected to present a clinical update on his/her patients during Rounds, as well as be attentive to the presentation of other patients, and attendant milieu issues. The Intern will also run the Thursday (10AM) Community Meeting, as well as the clinical "post" meeting to discuss milieu issues as they emerged from the Community Meeting. On Fridays at 11.15 AM the Intern will co-lead a psychotherapy group with the Supervising Psychologist which will focus on a selected group of patients who are appropriate for the group (that is, not acting out etc.) and the emphasis will be on interpersonal issues as they relate to the treatment of the patient, as well as psychoeducation and substance abuse issues

Notes and Documentation:

Emphasis will be placed from the beginning on the importance of documentation with the expectation that the Intern will learn rapidly to document a mental status note on his/her patients which includes an assessment of the patient's presenting symptoms, progress, and measureable goals and objectives, as well as need for inpatient level of care. Special attention will be paid to assessing and documenting issues related to dangerousness such as agitation, suicidal and homicidal ideation. The intern will be responsible for writing at least two progress notes per week which must be countersigned by the Supervising Psychologist who will write at least one clinical note per week. The intern will be encouraged to read the clinical chart on

his/her patients daily, and to review any notes written by Nursing Staff in the Prism computer system so as to obtain a rounded understanding of the patient's clinical situation from a multidisciplinary perspective.

Supervision, Consultation/collaboration with Psychiatrists, other Staff (Social Work, Nursing, Occupational Therapy, etc.), and Rounds, Team Meetings, Staff Meetings, and Case Conferences:

Supervision will be provided by the Supervising Psychologist on an ongoing basis as his clinical hours on the Unit largely coincide with those of the intern, and he sees all of the intern's patients as well as patients in his own case load. The supervision takes two basic forms; the intern will meet with the Supervisor for specified periods of time during the week, but will also be receiving ongoing supervision in an ad hoc, as needed way as clinical situations, dilemmas, and so on are encountered during the day to day management of clinical issues on the Unit. The intern is encouraged to bring up issues at any time, and to call the Supervisor or e-mail him when not on the Unit. As time management is a skill which all staff need to master on a busy, fast moving inpatient Unit the intern will learn to prioritize concerns and get feedback from the Supervisor (as well as other clinical staff) in a timely manner. The intern is also encouraged to seek out other staff on the Team, including the Attending Psychiatrist and Social Worker, as needed, in addition to raising issues in Team Meetings and Rounds.

The Intern will be responsible for familiarizing himself/herself with the medications that the patient is taking, and for maintaining an ongoing dialogue with the Attending Psychiatrist about how the patient is responding, as well as being alert to possible side effects of the medications. The Intern will also co-ordinate with the Social Worker to reach out to, engage, and maintain contact with family members and significant others, as well as set up and direct family meetings during the patient's stay on the Unit. The Intern will also co-ordinate disposition issues with the Social Worker, beginning with the initial evaluation, as for some patients the length of stay is quite short and consideration must be given to a full disposition from the outset.

Once weekly (Thursday at 10.30AM) the supervisory clinical staff will meet with all trainees to either discuss a relevant journal article (Journal Club), or observe a patient being interviewed by a clinician from outside the Unit. It will be the responsibility of the intern during his/her tenure on the Unit to prepare an article for presentation in Journal Club, and to present a patient (with clinical write-up) to an outside discussant. The Supervising Psychologist will assist the intern with preparation of the above.

Appendix B

MSSL
Outpatient Psychiatry
Clinic/Psychiatric Recovery Center

Orientation Manual
2019



**Mount
Sinai
St. Luke's**

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**Orientation to Mount Sinai St Luke's
Adult Outpatient Psychiatry Clinic (OPC)
and
Psychiatric Recovery Center (PRC)**

Mission Statement

We are a multidisciplinary team of mental health professionals committed to providing excellent clinical care and dedicated to developing future clinicians through innovative education and training. Our goal is to provide comprehensive, integrated behavioral healthcare to a multicultural community according to each patient's individual needs. We strive to provide compassionate care using the highest standards of practice to promote our patients' emotional wellbeing so that they may lead richer, more meaningful lives.

Our mission is to help individuals in developing greater satisfaction and success in daily living. This includes achieving symptom resolution, preventing relapse in chemical dependency, improving physical wellness, but most importantly, helping people engage in attaining personal goals, including occupational, educational, social, health, and/or family.

Welcome to the Adult Outpatient Psychiatry Clinic (OPC) and the Psychiatric Recovery Center (PRC)! Whether you are a staff member or trainee, you are a valued member of this clinic and we hope you will help us in fulfilling this mission. Your professionalism and the quality of services you provide will help us offer excellent care and create a positive environment for both your patients and colleagues. Your patients will rely on you to be available and responsible, empathic and knowledgeable, careful and caring.

We are part of the **Division of Ambulatory Services**, one of four divisions within the Department of Psychiatry and Behavioral Health at the Mount Sinai St. Luke's and West Hospitals. Within the Division, there are three main clinics, the OPC, the PRC, and the Center for the Intensive Treatment of Personality Disorders (CITPD). The Comprehensive Assessment Center (CAC) serves as the entry point for all patients interested in outpatient services.

Common to both clinics, a multidisciplinary staff of psychiatrists, nurse practitioners (NPs), psychologists, social workers, and trainees in psychiatry, psychology, and social work offer personalized, evidence-based, effective treatments in both English and Spanish. Therapeutic modalities include cognitive behavioral, dialectical behavioral, supportive, psychodynamic, and integrated co-occurring disorder treatments, as well as psychological and neuropsychological assessment. Both clinics provide mental health care including individual, family and group therapies, integrated care for comorbid substance use disorders and medical disorders, primary care and medication management. In addition, we have a medical nurse practitioner on site (6th floor) that provides primary medical care to a portion of our patients from both clinics. Furthermore, care coordination is available through our on-site Health Home team.

Clinic Hours:

Monday & Friday 8:30 a.m. to 5:00 p.m. and on

Tuesday, Wednesday and Thursday 8:30 a.m. to 7:00 p.m.

Patients must be seen during open clinic hours and within the clinic location.

Admission Criteria: The Division's services are available to adults ages 18 to 70 and in need of psychiatric care.

Exclusion criteria for OPC/PRC

- * Active suicide or homicide plan (as patient may need psychiatric hospitalization prior to admission)
- * Mental retardation/developmental disability (refer to OPWDD program)
- * Dementia, significant cognitive impairment, traumatic brain injury
- * Significant eating disorder (refer to eating disorder program)
- * Split treatment (unless approved by clinic directorship)
- * Requests for one-time evaluation for legal issue, disability, ACS or housing
- * Primary Substance Abuse (refer to Addictions Institute or other substance treatment facility)

Exclusion criteria can be somewhat flexible for Autism Spectrum (formerly Asperger's) and traumatic brain injury depending on severity.

Disposition decisions are generally made at the time of the patient's second appointment, as the first two appointments are for pre-admission evaluation. Typically, medications are not prescribed during the initial assessment though in rare cases, a patient may be formally admitted and prescribed meds. All intake evaluations done by trainees/residents must be co-signed by the appropriate supervisor.

Patient Care and Coverage: All clinicians are expected to manage the care of their own patients, which includes checking for phone messages from patients daily at minimum and collaborating with all providers on the treatment team. Coverage by a colleague should be arranged for vacations, night float, and other times away from the clinic. See below for policies for unexpected illness coverage.

Assistance for emergencies can be provided by the Mobile Crisis Team and by the Department's Comprehensive Psychiatric Emergency Program (CPEP). There is an "on call" MD or NP available to assist with consultation for at risk patients and emergency medication. The calendar is available in outlook as Vacation/Night float/Coverage (access is shared by Associate Director).

A patient requesting medication refills should not be sent to CPEP for medication. This should be handled by the clinician who is treating the patient, or by the covering clinician, clinic senior or supervisor in the clinic.

Access to the Department of Psychiatry **Policies and Procedures Manual** is available through the intranet (via the home page). It is imperative that all staff understand these fully. Any changes to policies and procedures are communicated in staff meetings and by email to all staff.

All staff and trainees should feel free to bring any general concerns, administrative or clinical questions, clinically difficult issues, suggestions, complaints, or problems that a supervisor cannot assist with, to the Associate Director or Ambulatory Psychiatry Director's attention, either by email, phone, or in person at any time.

Key Personnel and Resources

Division of Adult Ambulatory Psychiatry Services

Chair, Department of Psychiatry, Mount Sinai St. Luke's and West

Prameet Singh, MD

x232208 prameet.singh@mountsinai.org

Director, Adult Ambulatory Psychiatry, Mount Sinai St. Luke's and West
(vacant)

Associate Director, Adult Ambulatory Psychiatry

Anthony DeMaria, PhD x235371 anthony.demaria@mountsinai.org
cell: (646) 574-9743 -urgent/after-hours matters

Director, Center for Intensive Treatment of Personality Disorders (CITPD)

Andrew Twardon, PhD x237881 andrew.twardon@mountsinai.org

Comprehensive Assessment Center

Hannah Chesser, LCSW x235561 hannah.chesser@mountsinai.org

Program Manager, Division of Ambulatory Psychiatry Services

Jessica Fields x231846 jessica.fields2@mountsinai.org

Utilization Manager, Division of Ambulatory Psychiatry Services and
Addiction Institute

Oryce Williams x237031 oryce.williams@mountsinai.org

Managed Care Coordinator, Division of Ambulatory Psychiatry Services

Nathan Michel x235384 nathan.michel@mountsinai.org

Administrative Support Staff

Office Manager

Maria Ortiz x237704 maria.ortiz@mountsinai.org

OPC/PRC Patient Service Representatives (PSRs):

Charlene Gill x23-4068 charlene.gill@mountsinai.org

Krystle Wells x236714 krystle.wells@mountsinai.org

Maria Madera x237668 maria.madera@mountsinai.org

Coureen Lawrence x235209 coureen.lawrence@mountsinai.org

CAC PSR

Wanda Cherry x23-5584 wanda.cherry@mountsinai.org

Shared contact for all PSRs (used for scheduling): opc.prc.psr@mountsinai.org

Support Services

Please direct all requests regarding locks/keys, telephone repair, engineering/maintenance, housekeeping and computer repair to the Office Manager.

Keys: All staff members are issued keys to the office(s) to which they are assigned. A fee of \$15.00 is charged for any key that must be replaced due to loss or theft.

Mailboxes: All staff members have assigned mailboxes in the Staff Mailroom on the 3rd or 5th floors. Please check your mailbox regularly for faxes and other paper communications. Communications

about policy and procedure and other clinic issues are usually made via e-mail or distributed at staff meetings.

Printing, Faxing, Scanning and Copying: Copy/scanning/fax machines are available on the 3rd, 4th, 5th and 6th floors for all staff. All clinicians' offices should have a printer and/or access to a networked printer.

Telephone and Email Messages

You can record the following on the "alternate greeting #1" message of your voicemail options:

"Hello, you have reached the confidential voicemail of [name and role] at Mount Sinai St Luke's Outpatient Psychiatric Clinic. Please leave a message and I will get back to you as soon as possible. If this is an emergency, please call 911, go to your nearest emergency room, or press 2 to be connected to the Mount Sinai St Luke's emergency room. To cancel or reschedule your appointment, please dial 212-523-7668 or 212-523-4071"

When you are on vacation or away from the office, change your voicemail message to the following (you can choose alternate greeting #2 so that after vacation, you can switch back to your pre-recorded message #1):

"Hello, you have reached the confidential voicemail of [name] at Mount Sinai St Luke's Outpatient Psychiatry Clinic. I will be out of the office until [date]. You may leave a non-urgent message and I will get back to you when I return. If you need to speak to a clinician before I return, please call the covering clinician [name] at [tel #] (or call the receptionist at 212-523-7668 or 523-4071 to request the covering clinician). If this is an emergency, please call 911, go to your nearest emergency room, or press 2 to be connected to the St Luke's emergency room."

When you are on vacation or away from the office, use your email "out of office" message to the following:

"I will be out of the office from [date] and will return on [date]. For any urgent clinical issues, please contact [covering clinician's full name]. I will respond to all messages upon my return."

AND

Put a sign on your door

"Dr. _____ is out of the office until [date]. For any urgent clinical issues, please contact Dr. _____ at [phone number]."

Emergency Policies and Procedures

Emergency Numbers:	Hospital Security Office (24 hr)	x4444
	Hunter Ambulance Services	718-372-0700
	411 W 114 th Security Officer	x231000 (for STAT assistance)
	Hospital Operator	00 or x235678
	Mobile Crisis Team	x236711

Medical or Psychiatric Emergency

Life-threatening medical or psychiatric emergency

- Call 911 (on your cellphone or via the hospital operator-00) for emergency care or for patients who are a flight risk (ambulance and NYPD will be sent)
- Situations requiring security
 - Dangerousness or violence, call x4444 or 911
 - And remove yourself from the situation if necessary
 - Security support for potential dangerousness or violence, call x231000 and request assistance "STAT"
 - And remove yourself from the situation if necessary

*****PLEASE NOTE:** St. Luke's Security Officers are not allowed to physically restrain patients. Patients in Ambulatory Services are free to leave. Once they leave hospital facilities, NYPD will be contacted if necessary.

Voluntary Transfers to CPEP

- Call Hunter Ambulance at 718-372-0700
- Inform the 411 W 114th Security Officer (at x231000), the front desk PSR, and clinic directorship that Hunter has been called so they can direct the paramedics and so you can have support in handling the emergency
- Clinicians should call the CPEP to inform them about the patient's history and reason for referral

Clinicians should never "walk the patient" to the Emergency Room.

Off-Site Emergencies

- Concerns about an emergency situation for a patient off the grounds of hospital, you should call 911 and ask police to do a "wellness check" or
- Mobile Crisis Team (MCT) can be sent out to check on patients
 - Our MCT can be contacted at x23-6711 or mct@mountsinai.org. Referrals should be submitted to NYC WELL or through emailing the referral information to the MCT.
 - If the patient is out of our catchment area, you will need to call 1-888-NYC-WELL or go online <https://nycwell.cityofnewyork.us/en/mct-referral-online-form/> to request Mobile Crisis
 - The Mobile Outreach Team (MOT) provides outreach in non-crisis situations, and can help with connecting inpatients to outpatient care as well as checking on patients who have missed appointments but are not in crisis. These referrals can be emailed to the MCT.

NY SAFE Act:

Any patient who meets the criteria of "likely to engage in serious harm to self or others" must be reported to the Director of Community Services (Exec Deputy Commissioner of Mental Hygiene at DOHMH) via the OMH 9.46 reporting form online, available at http://www.omh.ny.gov/omhweb/safe_act/. A slide show about the law is available at http://www.omh.ny.gov/omhweb/safe_act/nysafe.pdf.

The goal of this act is to prevent individuals at risk of harm to self or others from having guns or access to guns. We limit our reporting to those who are at such risk as to require referral to 911, the CPEP or hospital. All licensed psychiatrists, licensed psychologists, licensed nurses (including nurse

practitioners) and LCSW social workers are required to report, but unlicensed psychiatry residents, psychology interns, and fellows and LMSWs are not. Anyone who feels a patient should be reported should discuss the case first with clinic directorship prior to reporting. If the director is not available, you may speak to the Division Director or one of the other program directors.

The criteria for reporting and the decision to report should be documented in the chart along with your risk assessment and other usual documentation for this type of situation. We are not required to inform the patient about this reporting, though it may be helpful to explain it, just as we may sometimes let someone know we are reporting to ACS.

Security

It is important that everyone participates in ensuring a secure work setting. It is Hospital policy that all staff wears their identification badges at all times. This assists the Security guards in identifying staff, and is also helpful to patients.

The Security guards work Mondays and Fridays from 8:00 a.m. – 7:30 p.m., and Tuesdays, Wednesdays and Thursdays until 9:00 p.m. Show your ID each time you enter the building, as Security keeps close tabs on all persons entering 411 W114th Street. The Security guard is on-site to respond to security problems and to assist staff in preventing security problems from developing. You should not hesitate to enlist the guard's assistance (x231000) or call general Security (x234444) if you have a problem with a patient, or any other security-related concern.

If you need a Security presence for a dangerous situation, call Hospital Security at 4444 or call 911 (via the hospital operator- 00), depending on the urgency.

Please make every effort to safeguard your own property and the property of others. Items of value, such as purses and laptops, should not be left unsecured. Office doors should be locked when offices are not in use. If you do not have a locked drawer or filing cabinet in your assigned office, request one from the office manager.

In addition, if you enter or exit the Clinic during non-operational hours, it is essential that you make sure the front door lock is engaged as you leave. If you would like to plan to come in after hours or on a weekend, please contact the office manager so she can arrange a plan with security to allow you access to the building.

Computers

Each staff and trainee is assigned his or her own username, which will provide access to the hospital network from any hospital computer when you log on. Each person has a private directory (P or H drive) to save his/her own documents and access to a shared directory. Any documents not saved on the H or G drives may be deleted (i.e. you should not use "my documents" on the C drive).

The shared drive has important documents for your reference and is accessible via G:/Misc/STL1/groups/clinic

Our electronic health record, Epic, allows clinicians to electronically document clinical care and access relevant records of care. All clinicians must be trained in the use of Epic.

You may contact the helpdesk (x236246, or via online intranet request) or the Epic helpdesk (212-241-4357) for assistance with any computer/IT problems you experience. They can also assist in

setting up Citrix, which will allow you to access your personal drive, the shared drive, Epic and more from your home computer. Please use care to protect sensitive health information.

Confidentiality

Confidentiality is of the utmost importance. We are required to maintain the confidentiality of our patients' private health information, according to the Health Information Portability and Accountability Act (HIPAA) and professional ethical guidelines.

Remember it is your responsibility to secure confidential patient information. Confidential patient information kept in the office must be placed in a locked drawer after hours. Under no circumstances should hospital records, notes with identifiable clinical information or other confidential patient information be taken out of the building, whether to home or to another office. Do not put confidential patient information on USB/flash drives as these are not secure.

Please respect personal privacy by not speaking about patients or clinical issues in public areas, such as the waiting room, elevator, or outside the hospital.

Internet and Email: Use your Mount Sinai Outlook email account for communications with Mount Sinai Health System colleagues. In your office, you should access Outlook via Microsoft Office. There is also a web-based access to Outlook so you can use it when you are away from the hospital computers. You may email confidential clinical information within the Mt Sinai (mssm or mountsinai) system. When sending confidential information, you should use the initials of the patient in the subject line but not the full name of the patient. The body of the email may contain the name and the minimum amount of clinical information needed. If you need to email confidential information to an email address outside mssm or mountsinai, you must put #secure# in the subject heading of the email in order to encrypt the information. The recipient will need to create a passphrase to open the encrypted email.

It is inappropriate to engage in email or text communications with your patients. "Friending" your patients, or communicating with them on social networks (such as Facebook) is contrary to hospital policy. We advise you to ensure privacy settings are appropriately managed on any of your own social network accounts. See <http://icahn.mssm.edu/about-us/services-and-resources/faculty-resources/handbooks-and-policies/faculty-handbook/institutional-policies/social-media-guidelines>

Staff Meetings

Staff meetings are held on Thursdays from 2pm-3pm in the 4th floor group room. No patients or other appointments should be scheduled at that time. All permanent staff, residents, fellows, and trainees are required to attend. Attendees are expected to be attentive, and to avoid using electronic devices during the meeting. Adequate time should be allotted to get to one's next appointment without leaving before the end of the staff meeting at 3 pm. All staff and trainees are responsible for knowing and implementing information addressed during these meetings.

On alternating Wednesday the Prevention, Education, Evaluation, Rehabilitation (PEER) in Early Psychosis Program staff meetings are held on the 3rd floor in the conference room, Suite A. on alternating Wednesdays from 10-11a.

Staff Attendance

Time Sheets

Staff are required to submit a Staff Time Sheet every other Thursday (except those who are 1199 employees, which is every week). Completed forms should be returned to the office manager on Thursday by 10:00 a.m.

Trainees are required to submit timesheets to the Education Department (Jackie Rivas, jacqueline.Rivas@mountsinai.org)

Unanticipated Absences by Clinicians

Unanticipated absences include: sick days, emergency personal days, unanticipated lateness, and unanticipated need to leave early.

Who to notify when out of the office:

- Clinic Director(s)
- Program Manager
- Patient Service Representatives (via opc.prc.psr@mountsinai.org)
- Office of Education for trainees (Jacqueline Rivas, jacqueline.Rivas@mountsinai.org)
- Admissions Supervisor/CAC

Notify everyone each day you are out sick

If you are out 3 or more days, you will have to submit a “Medical Substantiation/Proof of Illness Form”. If you are out sick 3 or more days, you will also need to get clearance to return by EHS.

All clinicians should arrange coverage when out of the office. The PSRs will take care of notifying patients when you are out unexpectedly.

VACATION REQUESTS

- Vacation requests must be made at least **two months** in advance.
- Fill out the appropriate form, online or hard copy. (forms found on the shared drive)
- Once approved and signed by the clinic director(s), email or hand in to the office manager (and the appropriate training staff for trainees).
- Please make sure to email the CAC to inform them so no intake or admission/PE visits are scheduled during time while you are away.
 - If you have not given two month’s notice and CAC has scheduled a patient for you, it is your responsibility to reschedule the patient.

Appointment Scheduling

Main PSR tel #: 212-523-4071 or 212-523-7668

PSR Email: opc.prc.psr@mountsinai.org

Standard workflow:

- Pt registers at front desk (3rd or 5th floor)
- Clinician meets with patient
- During session, clinician fills in disposition in Epic under LOS section (in the Close Visit tab) with timeframe for next appointment (x weeks) and enters type of visit (e.g. PA30 for psych)

assessment visit, or PT30 or 45 for psychotherapy) in the “For” section and include if patient is on clozapine or an injectable medication

- Clinician prints after visit summary (AVS) for patient and ensures that patient takes AVS to Centralized Scheduling PSR to schedule next appointment
- Metro cards can only be provided after the visit. **PSRs are not available to give Metro cards after hours**, so please make sure your patients are done by the end of clinic hours.

Reschedule request:

- Patient calls Centralized Scheduling PSR to reschedule appointment
- For low risk patients, PSR will make 1 outreach attempt, after which the clinician must make a determination about further outreach or discharge
- If patient is high risk, clinician is responsible for all outreach

No-show:

- Please see “Guidelines for Contact, Outreach, and Discharge”

Late patient:

- If patient shows up within 15 min of appointment, clinician decides whether patient can be seen. If later than 15 min of appointment, PSR checks with clinician prior to arriving patient and PSR will reschedule patient if appropriate

Recurring appointments:

- Enter recurring appointment on the disposition section of LOS, with end date for recurrence
- Email opc.prc.psr@mountsinai.org to provide the recurring appt details. Please inform them if it is an appt for injectable medication so that prior authorization can be obtained.

Groups:

- Submit group roster to admin staff for the following month by the last work day of the previous month (including patient names, DOB, and group leader who will be billing and writing the notes that month)
- Any changes to the group roster must be made one week in advance
- If you are canceling a patient for 1+ group sessions, inform the PSRs
- If a patient is being discharged from group, notify admin staff

You will be asked to submit a Master Schedule to the Program Manager and Office Manager which will be used to set up your schedule. It is important to keep your schedule accurate and up to date, as PSRs will use centralized scheduling to put patients directly into your schedule.

Check your schedule in Epic each morning because patient appointments can change quickly and an appointment may have been scheduled for you by a PSR. Please contact PSRs via the shared PSR email for any scheduling changes you are aware of that need to be reflected in your centralized schedule.

Admissions, Referrals and Transfers

All PGY3 residents are required to conduct intakes and/or psychiatric evaluations for new OPC/PRC patients every week. PGY2s and Senior Residents also conduct psychiatric evaluations as assigned. These are supervised by an attending psychiatrist from MSSL who will electronically co-sign your note. Please provide the CAC **at least two months’ notice** if your vacation or night float will occur on your scheduled intake days.

Our clinics accept the great majority of patients referred to us, though sometimes a patient may be better served by another clinic at MSSL or outside MSSL, or occasionally, in collaboration with another clinic. The intake supervisor will assist in determining if a patient is appropriate for admission or referral. If your supervisor is unsure of community resources, please contact the Supervisor of Admissions for suggestions.

CAC and OPC/PRC ADMISSIONS PROCESS

- Please see “Checklist for Intakes Discharges and Tx Plans” on the shared drive
For no-shows in CAC at 411, CAC will take care of outreach.

Readmissions to OPC or PRC without Assessment Center

Patients returning to OPC or PRC from inpatient psychiatric hospitalization

- Pt should be discharged from OPC/PRC by primary clinician upon admission to psychiatric hospital (and clinic director(s) should be alerted).
- Inpatient team communicates directly with OPC/PRC clinician as per following protocol (without involvement of CAC):

On day of admission and during hospitalization:

- 1) inpatient team emails outpt team on day of admission to inform about admission and maintains communication to coordinate tx plan/dispo
- 2) outpatient clinician notifies treatment team and clinic director of admission
- 3) If pt is not appropriate to return to clinic, inpatient team is notified

Prior to discharge:

- 1) Inpatient team discusses discharge plan with pt AND outpatient treatment team
 - 3) Inpatient team verifies insurance for outpatient care and medications
 - 4) Inpatient team completes health home/ICM/SCM app, if indicated
 - 5) Inpatient team faxes or emails discharge summary to outpatient primary clinician
- On return to OPC/PRC
 - Primary clinician does assessment
 - MD/NP/DO – Psychiatric Evaluation
 - Non-MD – re-intake template

Patients returning to OPC/PRC within 3 months of discharge

- If return to OPC is appropriate level of care:
 - Managed care coordinator verifies insurance.
 - Previous clinician does a psychiatric evaluation or re-intake and writes new treatment plan.
- If return to OPC/PRC is not indicated, primary clinician should review decision with clinic director(s) and then discuss with pt to work on alternative plan of care.

Internal Referrals

PRC and OPC are under one clinic license. Accordingly, patients do not need to be formally

transferred from OPC to PRC or vice versa. Additionally, it is not uncommon for patients to be serviced in both PRC and OPC.

CITPD has a separate license from the 411 programs, so a formal discharge and new admission should be completed when transferring from or to CITPD.

Child and Family Institute (CFI) transfers to adult clinics also warrant a formal discharge from CFI and intake to the adult clinic.

Internal transfers from other SLW clinics to OPC/PRC

- 3-4 weeks prior to planned discharge from clinic, the primary clinician will email a referral form to the OPC/PRC director, cc'd to the transferring clinic's director
- Email Managed Care coordinator to verify insurance and authorization
- If accepted for intake evaluation, an intake clinician will be assigned
- Insurance should be checked by referring clinic prior to the intake appointment, and will be verified by OPC/PRC PSR when patient registers for pre-admission evaluation. If HEAL center assistance is needed, patient should be informed by referring clinic staff.
- The OPC intake clinician will contact the referring clinician to discuss the case before the intake interview.
- OPC/PRC will complete the evaluation and notify the referring clinician about the disposition within 2 weeks from the referral date (after the intake is completed).
- If admitted, the pt may be discharged from the referring clinic after the admission is completed (generally the second visit). If not admitted, the referring clinic will work on an alternative discharge plan.
- OPC/PRC and referring clinic directors will monitor the referrals and will problem-solve as needed.

Referrals from OPC/PRC to other SLW clinics

- 3-4 weeks prior to planned discharge from clinic, the primary clinician will email a referral form to the receiving clinic director and cc the OPC/PRC director as well
- The receiving intake clinician will contact the referring clinician to discuss the case before the intake interview, if indicated.
- The Managed Care coordinator will verify insurance prior to intake
- If accepted for intake evaluation by the receiving clinic, an appointment will be given by that clinic.
- The receiving clinic will complete the evaluation and notify the referring clinician about the disposition within 2 weeks from intake
- If not admitted to the receiving clinic, the OPC/PRC will work on an alternative discharge plan.
- OPC/PRC and receiving clinic directors will monitor the referrals and will problem-solve as needed.

<i>Patient Lists</i>

All clinicians are expected to update our active patient list on the shared drive monthly when patients are admitted and discharged. Primary clinicians are responsible to keep all info on this list up to date. G:\Misc\STL1\groups\Clinic\411 OPC_PRC Patient List

Medications

All medication prescriptions must be written using Epic and prescribed electronically. The authorizing provider should be the attending or the resident's supervisor.

An adequate supply of medication should be provided to last until the next appointment. Refills may be written if clinically indicated and allowed, but not on a first visit, and not for more than 3 months of medication total at any time. Controlled substances should not be renewed without meeting the patient.

Your HCS (I-STOP) account should be set up with the hospital DEA and your suffix as your identifier. Any time a controlled substance prescription is written, I-STOP must be checked and the reference number should be written on the progress note (it can also be entered onto the prescription, utilizing the edit function in the sig section).

If patients have panic disorder or ADHD, you are allowed to provide controlled substance refills (see <https://www.health.ny.gov/publications/1477/>) However, you should not prescribe controlled substance refills unless your patient is stable and reliable, has been in the clinic at least 3 months, and has no history of substance use disorder.

Medication must not be kept in offices. By departmental policy, no sample medications are to be given to OPC/PRC patients. Sales representatives from pharmaceutical companies are not allowed in the clinic at any time. Hospital policy prohibits them from accessing clinicians in any patient care space. If you see them, please let them know this policy and notify the Ambulatory Director.

Patients requiring financial assistance may be directed to the HEAL Center to apply for Medicaid or the clinician may request free medication from a pharmaceutical company patient assistance program (if the patient has a low income and no insurance to cover medications); this medication should be stored in the locked Medication Room on the 5th floor. For patients with Medicaid pending, HEAL can provide a voucher is available that allow them to obtain medications temporarily at the Town Drugs Pharmacy.

Intramuscular (IM) medications are given in the PRC and are stored in the locked medication room. Discard all sharps in sharps containers. Do not keep needles, syringes, meds, etc in your office. Sharps containers must be exchanged for an empty container when they are $\frac{3}{4}$ full.

Individual Therapy Referral Guidelines

Many individuals can benefit from individual therapy, but there are limited resources in OPC to provide this modality. Supportive visits with the doctor can be effective treatment for many individuals, and is preferable for some. Group therapy is proven to be effective and is an excellent option for many.

All requests for individual therapy (using Psychotherapy Referral Epic Smart Phrase—See smartphrase list in this document) must be sent to the Associate Director of Adult Ambulatory Psychiatry for approval and assignment.

The individual therapist should determine a therapy treatment plan at the outset with the pt. Time-limited therapy should be the norm given our limited resources, with a planned timeframe of 6-12 months depending on the problem. No one should be offered unlimited therapy. Time-limited therapy may terminate according to the timeframe agreed upon or when appropriate goals are met,

or frequency of visits may be tapered over time as the patient improves clinically. If a patient misses more than 25% of all visits, the therapist should strongly consider termination of therapy as per discharge guidelines. A patient or therapist who requests continuation of therapy for more than one year must receive approval by the Director and or Associate Director (through written or verbal description of the rationale for continuation).

Interpreter Services

- In-person
 - Call page operator 23-2828 and enter pager 33853, then enter your phone number
 - This may take up to 15-20 minutes since there is only one interpreter for the hospital at this time so you should plan ahead
 - If you need an in-person interpreter after 5 pm, you can call during business hours to schedule
- Phone services
 - Call 36-5096 24 hrs a day

Patient Annual Physical Examinations and Medical Information

The NYS Office of Mental Health and MSSL policy require that all psychiatry patients receive annual physical examinations. The time and place of the examination must be documented in the treatment plan.

Patients seen for primary care outside of the Mount Sinai system should provide a copy of the required physical exam and labs or sign consent for the clinician to obtain this information.

A copy of the physical and any labs should be obtained and placed in the mailbox for documents to be scanned (after the clinician reviews it). Psychiatrists may additionally order labs as needed.

All patients with diagnosis of Bipolar Disorder, Schizophrenia or Schizoaffective disorder AND those taking antipsychotics will require screening and monitoring for DM with HgA1c and CVD (Cardiovascular Disease) with LDL, at a minimum of frequency of every year.

Full medication reconciliation should also be completed regularly, listing both psychiatric and non-psychiatric medications. Epic has a tab to reconcile all medications, at the initial eval and after changes are made to medications.

Alternatively, you may provide the pt with the attached **SLR Medical Information Form** (Appendix E, also available on the hard drive G:\Misc\STL1\groups\Clinic\411 OPC Forms, Letters and Treatment Guidelines\411 Primary Care Forms) for their primary care provider to complete and send back to you for review.

The Outpatient Division has a PCP on site part-time. Appointments may be made through Wanda Cherry, PSR, and sending the spic smartphrase of .PRIMARYCAREFERRAL to NP Elizabeth Jones.

Patients may also be sent to the University Medical Faculty Practice (UMPA- at 1090 Amsterdam Ave), Ryan Center (on Amsterdam Avenue at 97th St.), or the Ryan-Chelsea Clinic, to schedule an appointment for a physical and to find a primary doctor. For increased integration of care and better communication between PC and psychiatry, we recommend Patients to have their PC on -site or within a MSHS facility (shared electronic health record).

It is important that at some point during the Patients care, the psychiatrists/NP makes contact with Patients PCP to ensure communication and confirm health status or any concerns. Documentation of such efforts will be part of the record (as a tel call or miscellaneous encounter).

When it is clinically indicated that an on-site toxicology test be performed on a patient, the physician may send the pt to the nurse practitioner on the 6th floor for a test even if the patient is not seeing the NP as his/her primary provider.

If the patient has not had a physical examination within one year, OMH requires that he/she be referred quarterly, and that this be documented in the medical record on the treatment plan.

When patients refuse PC, treating psychiatrist requests a written acknowledgment understanding the importance of physical health yet declining referral.

Template to be used for medical information in addition to Problem List and Medical History (prescribers should document this in the Epic psych assessment note):

Recent medical problems/complaints/ROS:

Primary care provider (PCP) name and phone number:

Date of last physical exam:

If no PE in past year, document efforts to obtain it:

Medical diagnoses (in Epic problem list)

Lab and test results, vital signs with dates (enter if not auto-populated in Epic):

Full medication list in Epic (reviewed with pt and/or PCP):

 Psychiatric:

 Non-psychiatric:

Referrals/Recommendations:

CAC Intake folder contains health assessment screen:

Upon initial evaluation to the clinic, patients complete several screening tools and consent forms contained inside a green folder. These will later be scanned into the record and can be found in the Media section in Epic. As part of psych eval, the MD/NP reviews and acknowledges these screening tools, including health assessment and makes recommendations as necessary.

Document in treatment plan template (all primary clinicians document when completing treatment plan):

PCP name and phone number

Weight, BMI

Date of most recent physical exam

PGO (problem, goal, objective) related to medical needs, if indicated

Psychiatry to Primary Care Referral

Psychiatric provider gathers insurance type and insurance ID # along with patient demographics and faxes to the UMPA Patient Account Supervisor, at 212-523-7399 (tel # 212-315-0144 ext 1444).

Eligibility will be determined and the results sent to the UMPA Call Center who will make appointments for those eligible and communicate back to the referring office/provider with date and time of appointment and primary care provider contact information. UMPA Call Center will also report back to the referring office /provider on patients that are ineligible.

High Risk Patients and Safety Plans

Patients are considered high risk if they meet any of the following criteria:

- Significant suicidal or homicidal ideation
- Recent suicide attempt, self-injurious behavior, threatening behavior or violence
- Recent emergency room visit or hospitalization for unstable psychiatric or medical illness

In Adult Ambulatory Psychiatry risk level is assessed by

- Completing intake template risk assessment section
- SRA (suicide risk assessment) upon intake and every 6 months if considered non-HR, every 3 months or as needed if HR
- VRA (violence risk assessment) upon intake and every 6 months if considered non-HR
- Clinical risk is monitored in every med mgmt. or psychotherapy session

High Risk (HR) patients are identified, flagged in the record and listed in the HR patient roster by Clinic Directors. SRA (and/or VRA) will be repeated at a minimum frequency of quarterly, along with reviewing/updating safety plan. This commonly happens during treatment plan review. However SRAs shall be repeated every time there is clinical concern for increased risk. Please refer to MSSSLW Psychiatry Outpatient Risk Assessment, Suicide Risk Assessment and Violence Risk Assessment Policies and Procedures in MS intranet for further guidance.

SRAs and VRAs can be created in EPIC via the smartphrases .SRAOPD and .VRAOPD

Safety plans should be developed with all moderate and high-risk patients (form available in shared drive and via EPIC). The plan asks the patient to identify stressors and triggers, coping strategies, crisis plans, and emergency contacts. The patient should sign and date the form and receive a copy of the form. The clinician should make sure the plan is scanned into the Epic chart and a copy given to the Clinic Director. (See separate table for risk determination guidelines).

Incident Reporting

In the unfortunate case of an adverse event or incident with your patient, please contact the clinic director immediately for assistance, support and guidance. Incidents of moderate to severe degree of harm and/or risk (eg suicide attempt, assault, death by any cause) must be reported to the Office of Mental Health and the Justice Center. The clinician will fill out the incident reporting forms, then the clinic director will review the forms prior to sending these to the director of QI who will then submit them to OMH and the Justice Center. All deaths including both active patients and patients who have been discharged within the past 30 days must be reported. Contact notes should be written in the chart to report news of an incident, and a discharge summary is written in case of a death.

Serious incidents are reviewed in the monthly Divisional QI/QA meetings and the weekly Safety and Quality Committee. At times, these are individually arranged with the treatment providers, clinic and division director, and director of Quality Initiatives and Outcomes. The purpose of these is not to cast blame but rather to assess the possible causes for a bad outcome and how we might respond more effectively as clinicians and as a system to prevent future adverse events.

The Dept of Psychiatry incident policy is available on the shared drive, as are the forms for incident reporting to OMH and the Justice Center: H:\Misc\STL1\groups\Clinic\SAE Policy

Closing Encounters

Encounters are visit notes that are due to be completed and signed (closed) within 48 hours of service. This ensures quality of care as information needs to be available to other clinicians involved in the patients' care. Open encounters are also services in which billing cannot be completed. Reports go out regularly to notify providers when they have open encounters. Program leadership is involved in making sure these encounters are closed and co-signed in a timely way.

Patients' Rights and Quality of Care

It is the responsibility of all providers in OPC/PRC to provide treatment in a manner that recognizes and protects the rights of our patients. New York State specifies rights for hospital patients in general and psychiatric patients in particular. Both lists of rights apply to our patients. You should review these rights, become familiar with them, and act in accordance with them. Three rights worth particular mention are:

The right to complain without fear of reprisals about the care and services

The Division has a well-articulated patient grievance procedure (see Policies and Procedures on hospital intranet) in which staff plays an important role. All staff needs to have working knowledge of this procedure. Staff is expected to handle all complaints accordingly, especially those concerning treatment they themselves are providing to one of their patients. All staff is responsible for creating an environment in which patients feel safe to complain when they are dissatisfied, without risk of reprisal.

Privacy and confidentiality of all information and records regarding treatment

We have a special responsibility to maintain the confidentiality of our patients. Potential violations of this policy are waiting room and elevator conversations between clinicians or between clinicians and patients that should instead occur in an office, and taking written patient information out of the office.

Participate in all decisions about treatment

Patients receive better care when they lead in identifying their goals and actively collaborate in treatment planning with their providers. The State Office of Mental Health requires that psychiatric outpatients participate in treatment planning, and indicate they have done so via the patient's signature on their treatment plans. When it is not possible to include patients in treatment planning, the clinician is required to document that this is the case and explain why.

Patient Satisfaction Surveys are currently distributed yearly, usually in November. Results are tabulated by the Director of Quality Initiatives. They are reported to all clinic staff and to the Department Chair and Administrative Staff. OPC/PRC strives to improve patient satisfaction by requesting this feedback, analyzing these surveys, and discussing them at staff meetings. OMH requires a 50% response rate; thus your help is key in motivating your patients to fill out these surveys.

The Justice Center's Vulnerable Persons' Central Register requires that all staff and trainees in the clinic who have clinical contact must sign a code of conduct on an annual basis that includes the following standards for care: person-centered approach; physical, emotional and personal well-being; respect, dignity and choice; self-determination; relationships; advocacy; personal health information and confidentiality; non-discrimination; integrity, responsibility, and professional competency; and reporting requirements (of all reportable incidents to the Central Register at 855-373-2122).

Welcome to Mount Sinai St Luke's Psychiatry
The Adult Ambulatory Clinics seek to provide you with high-quality care
to promote your mental health, wellness, and recovery.

What you can expect from us:

- ❖ *Excellent, effective care* - focused on your individual needs and goals
- ❖ *Confidentiality* - you may choose to give consent to share information with others, such as family or other providers
- ❖ *Availability*- on time, reliable care and alternative coverage when we are not available
- ❖ *Respect* – compassionate, respectful response to your concerns
- ❖ *Hope* – we believe in your capacity to succeed in getting well and achieving your goals

What we expect from you:

- ❖ *Engagement and Motivation*- Please engage with your treatment providers to create and actively participate in your treatment plan to work towards your goals. We will support you in this process.
- ❖ *Timeliness* - Arrive 10-15 minutes early to register for your appointment. If you need to cancel or change your appointment, call at least 24 hours in advance and reschedule.
- ❖ *Attendance* – Commit to attend all your appointments. We can work with you to overcome any obstacles to your attendance. If your attendance falls below 75% over two months, we will need to discuss other treatment options including discharge from the clinic.
- ❖ *Inform* – Let your clinician know about any important issues or safety concerns; let your prescriber know about any side effects or medical problems; let the staff know about any changes in telephone number, address, insurance.
- ❖ *Respect and Safety* - Treat others with respect in the clinic. Yelling, cursing, threatening, or other verbally abusive behaviors are not acceptable. Violence or threats of violence to staff or other patients will result in termination of care from the clinic. Weapons may not be brought into the clinic.
- ❖ *Address Substance Use* – We will work with you on substance issues as well as mental health.
- ❖ *Ask questions and give feedback* – We will be happy to answer any questions you have about your treatment. If you have concerns, recommendations or complaints about your treatment, please feel free to discuss with your provider, the front desk receptionist, or the clinic director.
- ❖ *Plan for the Future* – Upon completion of each stage of your treatment goals, you and your provider will work together to make a plan for your future treatment, if needed. If you decide to end treatment before this, please let us know so we can assist you with a follow-up plan.

I have read these expectations and agree to follow them.

Patient name _____ Date of Birth _____

Patient signature _____ Date _____

Clinician name _____

Top 10 List for Good Clinical Care

10. **Documentation.** Write a note every time you do patient-related care (eg in-person visit, telephone call, collateral discussion). Document the time and length of the visit.
9. **Patient's voice.** Include in assessments the recipient's view of past successes, difficulties, desired outcomes, and potential barriers. Give the recipient a voice in the process of deciding his or her treatment plan.
8. **Collaterals.** Involve family and significant others to complete assessments and treatment planning where indicated and with the recipient's consent. Obtain information from prior providers, collaborate with current providers (e.g. case management, probation, housing providers, other doctors or therapists).
7. **Person-centered, strengths-based, recovery-oriented treatment planning.** Treatment plans should identify life role goals (eg work, education, parenting) as well as symptom reduction; focus on strengths as well as deficits; and strive to be person-centered. Quote the recipient's language, and include him or her in planning. Write the treatment plan with the recipient and make sure he or she signs.
6. **Risk assessments.** Do complete risk assessments for suicide, homicide, and other risks, including information from collaterals where indicated. Create a safety plan, including identification of triggers, warning signs, coping strategies, support team (including family, friends, providers), emergency plans and emergency contacts. Identify past and current trauma, risk of perpetrating violence or being victimized, and know how to provide appropriate support and refer to available resources. Consult with colleagues/supervisors when unsure what to do.
5. **Health assessments.** Ensure health screening and monitoring including blood pressure, BMI, smoking status; collaborate with primary doctor. Obtain documentation of a yearly physical exam.
4. **Co-occurring disorders.** Identify and engage in treatment of co-occurring disorders with motivational interviewing and dual diagnosis treatment. Do not treat substance use disorders sequentially, but rather concurrently.
3. **Outreach.** Do outreach if your patient does not show up or has disengaged from treatment- call, write, send Mobile Crisis if concerned about safety. Help overcome barriers to care (eg, transportation, insurance, prior authorizations). Before deciding to discharge, attempt adequate outreach, ensure a safety assessment has been done, and offer discharge options/referrals. These steps should be documented in contact notes and the discharge summary.
2. **More documentation.** Treatment goals, contacts, risks, discussions about medications, decisions to change or terminate treatment, decisions to hospitalize or not to hospitalize, consultations with supervisors and colleagues about difficult issues. Document collaboratively and concurrently.
1. **Hope and empowerment.** Give the recipient hope for improvement and recovery. Identify strengths that will help him or her succeed. Collaborate in all aspects of care.

Mount Sinai St Luke's - Ambulatory Psychiatric Services
Member of the Mount Sinai Health System
411 W 114th St, New York NY 10025
Tel (212) 523-7668 Fax (212) 523-7000

MOUNT SINAI ST LUKE'S MEDICAL INFORMATION FORM

Dear Medical Provider,

The patient below is participating in treatment in our clinic and we require medical information in order to ensure that we provide appropriate psychiatric care. **Please fill out this form and fax it along with a copy of your medical records (including recent physical exam, EKG and laboratory results).** Thank you for assisting in the care of this patient.

Patient:

DOB:

Psychiatrist:

Psychiatric Diagnosis:

Current Psychiatric Medications:

List of medical problems and treatment plan:

- 1.
- 2.
- 3.
- 4.
- 5.

List of medications prescribed:

Physical exam findings:

Weight:

Blood pressure:

PPD status:

Any positive physical findings:

Any contraindication to psychotropic medications?: No

Yes (explain):

EKG and other test results:

Comments:

Physician's signature:

Date:

Address:

Telephone #:

Epic SmartPhrases and SmartTexts

Epic Smartphrases are used for many aspects of our clinical care and documentation. Here are some common ones for OPC/PRC:

- Epic Template SmartPhrases (must be preceded by the dot)
 - .INTAKEEVALMDNP (Intake evaluation for MDs and NPs)
 - .INTAKEEVALTHERAPIST (Intake evaluation for psychology trainees, psychologists and social workers)
 - .READMIT (for non-MD/NPs)
 - .SRAOPD (Suicide Risk Assessment)
 - .VRAOPD (Violence Risk Assessment)
 - .PSYCHOTHERAPYREFERRAL (for referral form for psychotherapy)
 - .PRIMARYCAREREFERRAL (for referring patients to OPC NP Elizabeth Jones)
 - .CRISIS (crisis intervention note)
 - .MYDSRIP (for DSRIP Enrollment)

Epic also has many system created SmartTexts that are of use. Here are some common ones for OPC/PRC:

- MS BISLR BH CTP (comprehensive treatment plan)
- MS BISLR BH DISCHARGE SUMMARY (when discharging patients)
- MS BISLR BH PROGRESS NOTE (when documenting clinical services)



Checklist for Intakes and Discharges

***Patients should not typically formally admitted to either of the clinics until their 2nd visit

Intake Assessment (1st visit)

	Intake Assessment Template (Admission Evaluation 90791 or 90792)
	Complete Suicide Risk Assessment (SRA) for ALL patients
	Complete Safety Plan if patient is Moderate or High Risk according to Guidelines <i>3 copies – 1 for you, 1 for patient, 1 for Dr. DeMaria</i>
	Obtain PCP information or refer to Elizabeth Jones NP on 6 th floor *See Wanda in CAC to schedule with Ms. Jones
	Initial Comprehensive Treatment Plan if prescribing meds is necessary
	Releases of Information (If appropriate and especially important for moderate/high risk pts)
	Complete Disposition Form/Green Folder and return all paperwork to CAC

Second Assessment/Initial Psychiatric Evaluation (2nd visit)

Patients are not officially admitted until their 2nd visit

	On Service with Exam Template (non-MD/NPs) or Psych Eval (MD/NP/DO)
	Initial Treatment Plan Template and Flowsheet (be sure to add medical comorbidities and/or smoking cessation if appropriate)
	Additional Releases of Information (If appropriate)
	Order Labs
	DSRIP Enrollment (.mysdrip)
	Make Therapy and/or group referral
	Complete Any Relevant Research Referral Forms (if pt agrees)
	Complete Admit/Discharge Flowsheet

Discharges

Hospitalized patients are administratively discharged as they are technically out of our care
See Guidance sheet for guidelines regarding outreach and discharge

	Use Discharge Smartphrase Template in a Misc Enc
	Rationale for Discharge in the discharge note (see below)
	Brief Psychiatric Rating Scale (if patient was seen, otherwise, do not complete)
	Use Epic Template to send letter to pt with a minimum of 3 referrals
	Admit/Discharge Flowsheet

“Chief Reason for Referral” Section of Discharges – Please use one (or more) of the following

- * Pt nonadherent to treatment – Pt must wait 3 months from date of discharge and return via CAC intake unless approved by treatment team/clinic director(s)
- * Pt requires higher level of care – consult treatment team and/or clinic director (rationale provided below)
- * Pt should not be re-admitted to clinic (rationale provided below) - consult treatment team and/or clinic director(s)

- * Pt hospitalized – will be readmitted upon discharge
- * Readmission contingent upon: (list contingencies here)

Re-Admissions

Readmissions after inpatient hospitalization go directly back to treatment team unless otherwise determined by the treatment team/director(s)

	Use Re-admission template (therapists) or Psych Eval (MD/NP/DO)
	Brief Psychiatric Rating Scale
	Suicide Risk Assessment and if appropriate, a Safety Plan
	Admit/Discharge Flowsheet

Treatment Plan

Treatment plans are due every 90 days

	Open a Misc Enc – use CTP template and Treatment Plan Flowsheet
	Complete Suicide Risk Assessment (SRA) for ALL patients <i>3 copies – 1 for you, 1 for Dr. McKelvey, 1 to be scanned</i>
	Update/Review Safety Plan if patient is Moderate or High Risk <i>3 copies – 1 for you, 1 for patient, 1 for Dr. M (Dr. M will make copy to be scanned)</i>
	Brief Psychiatric Rating Scale (in Flowsheets)
	Order Labs (for patients with diabetes and/or on an anti-psychotic if not already completed)



General Guidance for Contact Frequency, Outreach and Discharge

I. Low Risk Patients

a. Contact Frequency

- i. First visit after intake should occur within *10 business days* of intake
- ii. Frequency of treatment visits TBD by treatment provider/team

b. Outreach

- i. Scheduling PSR will initiate contact the morning after a pt misses an appointment and will notify clinician via Epic message
 1. If contacting the pt is an urgent matter, please alert the Scheduling PSR
- ii. Scheduling PSR will make 3 outreach attempts after a patient misses an appointment
- iii. Pt misses 25% of appointments over 3 months and/or is frequently canceling scheduled appointments
 1. If not previously addressed, discuss a treatment contract with the patient

c. Discharge

- i. Any discharges should be discussed with the treatment team
- ii. When discharged for nonadherence to treatment and patient is low risk, patient must wait 3 months before returning to the clinic unless treatment team and/or clinic directorship decide otherwise or the patient is being discharged to us from the inpatient unit
 1. In the Discharge Summary, under "Chief Reason for Referral", indicate RTC date (or not to return to clinic) and rationale
 2. When the 3 month waiting period is finished, patient must schedule a new intake through CAC
- iii. If treatment contract has been previously addressed and patient continues to no show or is frequently canceling/rescheduling, send a letter with a final appointment and if patient does not show, discharge may be appropriate
 1. If discharging, send discharge letter with 3 referrals

II. Moderate Risk Patients

a. Contact Frequency

- i. First visit after intake should occur within *7 business days* of intake
- ii. Frequency of treatment visits TBD by treatment team
 1. It is advisable to increase the frequency of visits depending on acuity and level of risk, especially if there is a delay for individual and/or group therapy
 2. Weekly or biweekly visits are suggested
- iii. If a patient is being discharged from a service (such as graduating from therapy), consider increasing the frequency of visits and possibly referring pt to group therapy

b. Outreach

- i. Telephone outreach and documentation at the time of missed appointment
- ii. If unable to reach patient directly, an additional phone call should be made within 2 days of initial phone call

1. Consider calling patient's emergency contact if consistently unable to reach patient
- iii. Pt misses 25% of appointments over 3 months
 1. If not previously addressed, present patient with a treatment contract and discuss attendance
 2. If treatment contract has been previously addressed and patient is no showing despite outreach, consider sending MCT
- iv. It is not recommended to discharge patients with a moderate level of risk even if no-showing, especially if the patient is experiencing increased psychosocial stressors (e.g. changing treatment providers).
 1. Rather, outreach should intensify
- c. Discharge
 - i. Moderate risk patients may be appropriate for discharge when;
 1. Pt refuses treatment (document that you discuss with the patient the risks/benefits of refusing/terminating treatment)
 2. Mobile Crisis has been activated and patient is not able to be contacted (or refuses contact) and continues to fail to respond to outreach
 3. If discharging, send discharge letter with 3 referrals
 4. The 3 month waiting period can be waived if the treatment team agrees to take patient back into the clinic
 - a. If it is determined that the patient must wait 3 months, the patient must then schedule a new intake through CAC
 - ii. Pts are also administratively discharged when hospitalized for psychiatric reasons
 1. Pts are taken directly back into the clinic from inpatient hospitalization unless it is determined that a higher level of care is necessary

III. High Risk Patients

- a. Contact Frequency
 - i. First visit after intake should occur within *3-5 business days* of intake
 - ii. Frequency of treatment visits TBD by treatment team
 1. The frequency of visits should be increased for high risk patients and **weekly visits are strongly recommended**
 2. Refer for individual and/or group therapy
 - iii. If a patient is being discharged from a service (such as graduating from therapy), consider increasing the frequency of visits and referring patient to group therapy
 - iv. Telephone outreach and documentation at the time of missed appointment
 1. Depending on level of concern, consider 911, MCT and/or contacting patient's emergency contact
 - v. If unable to reach patient directly, an additional phone call should be made later the same day or the following day
 - vi. Pt misses 25% of appointments over 2 months
 1. If not previously addressed, present patient with a treatment contract and discuss attendance
 2. If treatment contract has been previously addressed and patient is no showing despite outreach, consider sending MCT
 - vii. When patient is not showing due to increased psychosocial stressors, outreach and care coordination should intensify
- b. Discharge
 - i. High risk patients are appropriate for discharge when;

1. Pt refuses treatment (document that you discussed with the pt the risks/benefits of refusing/terminating treatment)
 2. Mobile Crisis has been activated and patient is not able to be contacted (or refuses contact) and continues to fail to respond to outreach
 3. If discharging, send discharge letter with 3 referrals
 4. If the patient decides to engage in treatment, the patient can be taken back into the clinic immediately
 5. If the patient is not appropriate to return to OPC/PRC in the future, this should be noted in the "Chief Reason for Referral" section of the Discharge Summary (including a rationale for denial of services and/or the contingencies that must be followed before the pt can return)
- ii. Pts are also administratively discharged when hospitalized for psychiatric reasons
1. Pts are taken directly back into the clinic from inpatient hospitalization unless it is determined that a higher level of care is necessary
 2. If you are being pressured to take a pt back even when inappropriate for the level of care we can provide, please inform Clinic Director(s)

Appendix C

St. Luke's –Roosevelt Hospital
Department of Psychiatry
Center for Intensive Treatment of Personality Disorders:
Handbook

Program Description:

CITPD is a hospital-based, Article 28, Mental Health Clinic offering specialized, intensive outpatient treatment for persons diagnosed with a Personality Disorder or personality-related symptoms, including, but not limited to:

- 1 -recurrent suicidal thoughts, behaviors or gestures
- 2 -self-injurious behaviors
- 3 -impulsivity and / or high-risk behaviors
- 4 -identity / self-image problems
- 5 -interpersonal / relational / family problems and conflicts
- 6 -emotional / mood dysregulation
- 7 -dissociative symptoms
- 8 -social / interpersonal isolation
- 9 -problems with intimacy and trust
- 10 -sexual / gender-identity problems
- 11 -unusual perceptual experiences or thoughts
- 12 -body image problems
- 13 -addictive behaviors other than substance abuse / dependence
- 14 -shyness / inhibitions / fear of rejection
- 15 -difficulties in making decisions / excessive perfectionism

Treatment

An innovative treatment model for “difficult to engage and treat patients with severe personality disorders”. The model is “multidimensional” and “multivariable” – multiple dimensions of a personality disorder are treated simultaneously by multiple treatment variables within an Intensive Outpatient Program setting. Personality disorders are conceptualized as “enduring disturbances of neurocognitive system regulating patterns of internal experience, behavior and interpersonal adaptation”. Main dimensions targeted in treatment are (1) the attachment system; (2) neurobehavioral circuits underlying personality and temperament; (3) neurocognitive regulation of affects, mood and impulses; (4) psychodynamics of self, object relations and ego-functions; (5) cognitions and mentalization (6) patterns of relating and interpersonal behavior. Main clusters of treatment variables are (1) program structure (2) modality; (3) theoretical approach; (4) therapist (5) peer group dynamics; (6) self-transcendence (Zen mindfulness / meditation).

The Center offers integrated, intensive, multidimensional, highly individualized individual and group treatment including:

- 1 Dialectical Behavior Therapy [DBT]
- 2 Psychodynamic Therapy
- 3 Mentalization-Based Therapy
- 4 Cognitive Therapy
- 5 Psychopharmacology

We believe that psychiatric treatment, and psychotherapy in particular, is a unique, intricate and highly personal process of self-examination and self-transformation involving a complex sequence of interactions and interventions between the therapist(s) and the patient(s). It often entails a dialectic between validation and strengthening of what is adaptive in one's behavior and an effort to change that which is maladaptive and / or self - destructive. As a multidimensional/ multivariable process, psychotherapy involves a thorough exploration of problematic patterns of behaviors, feelings, cognitions, thoughts, interactions as well as other, internal and overt, aspects of one's functioning. It may also necessitate an in-depth exploration of unconscious and conscious aspects of current symptoms and behaviors. The process of psychotherapeutic change typically initiates and leads to new learning and problem solving, new understanding and insight, acquisition and rehearsal of new skills and behaviors combined with a development of a new, healthier lifestyle.

Staff

CITPD programs are staffed by an interdisciplinary team of clinical psychologists, psychiatrists, psychiatric social worker, psychiatry residents, psychology externs, interns and postdoctoral fellows undergoing their clinical training at St. Luke's-Roosevelt Hospital Department of Psychiatry.

Admission Criteria

Admission and program placement are based on a comprehensive assessment and review by CITPD multidisciplinary treatment team using the following criteria:

- 1 principal or secondary DSM-IV diagnosis of a Personality Disorder
- 2 ability and willingness to participate in intensive, group-based treatment
- 3 commitment to 5 days per week attendance and 6 month long treatment cycle
- 4 commitment to drug-free functioning and / or enrollment in concurrent substance abuse treatment, if needed
- 5 ability and willingness to comply with program policies and rules assuring safety of self and others

The MORNING(AM) program [9:45-12:00] - prominent and persistent (DSM Axis I) psychiatric symptoms and serious impairments of daily functioning combined with longstanding personality-related (DSM Axis II) interpersonal problems in treatment adherence, relationships, work or school.

The AFTERNOON-1 (PM-1) program [1:00-3:30] - serious, primarily personality-related, personal & interpersonal (DSM Axis II) problems combined with another, non-psychotic, psychiatric (DSM Axis I) syndrome. Substantial work and / or school experience.

The AFTERNOON-2 (PM-2) program [4:15-6:00] - a wide spectrum of acute, persistent, primarily personality-related, personal and interpersonal problems (DSM Axis II). Part-time employment or school.

The MODIFIED programs - meeting criteria for any of the above three main programs but having difficulties engaging and continuing in treatment or in transitioning to a less intensive level of care.

Location and Hours of Operation

The Center is open 9:30 AM – 7:30 PM, Monday – Friday, and is located at

Roosevelt Hospital, 1000 Tenth Avenue, New York, NY 10019,
Main phone #: 212-523-6983

Internship information

The 4 month internship rotation involves training within the AM program (9:30 – 1:00, M-F) and includes the following:

- 1 Training in co-facilitation of intense, integrative psychodynamic group psychotherapy, 3 x / week, 75 mins focused on severe personality disorders.
Interns will co-facilitate three therapy groups per week, under supervision of a licensed psychologist.
- 2 Training in comprehensive assessment of complex Axis I and Axis II psychopathology.
Intake evaluations and presentations in disposition meetings.
Interns will conduct and present 1-2 assessments per month, under supervision of a licensed psychologist
- 3 Training in short-term, intensive individual psychotherapy of severe personality disorders.
Interns will work individually with 1-2 patients at a time, under supervision of a licensed psychologist.
- 4 Training in Dialectical Behavior Therapy (DBT).
Interns will co-facilitate one DBT group per week, under supervision of a licensed psychologist.
- 5 Group and individual supervision in the intensive treatment of personality disorders.
- 6 Weekly team meetings
- 7 Weekly clinical meetings

Appendix D

Addictions Institute Handbook:

Program Description (i.e. type of unit, treatment approaches, intake and evaluation procedures, emergency procedures, discharge procedures, etc.):

The Outpatient Department of the Addiction Institute at Mount Sinai has programs that treat clients with substance dependency problems. The program treats a variety of substance problems including alcohol, heroin, cocaine, prescription drugs, and methamphetamine as well as other substances. The outpatient programs include three intensive programs that involve three or more hours of treatment as well as less intensive programs that meet once and twice a week for more stabilized clients. Other specialty programs in the outpatient department include a program for nurses, a crystal methamphetamine program for gay and bisexual men, a MICA program, and a program for young adults. In addition, we have an Evaluation Service that does intakes and places clients in the various programs. We also offer family therapy and psychopharmacology services. The majority of the clients at the Institute also have a psychiatric diagnosis as well. Clients stay for flexible periods of time depending on their progress. The outpatient department is part of a larger system that includes inpatient detoxification and rehabilitation services, an opiate replacement program as well as other outpatient programs. Interns are placed in the morning intensive program where an opportunity to co-lead groups with other professionals including psychologists, social workers, and CASACs. They also run and co-lead different topic oriented groups such as a parenting group, cognitive behavioral relapse prevention group. They attend weekly rounds and work with clients individually as needed. They are supervised weekly and attend daily rounds. In addition they run a twice weekly group that orients and engages new clients into the intensive day program.

Location, Hours, Program Contact Information (i.e. for clients, for staff):

The Unit is located at Mt. Sinai West Hospital on the 8th floor (1000 Tenth Avenue 8G NY NY 10019). Interns have IDs in order to gain access to the hospital and the unit and must wear IDs at all times. The director of outpatient is Joe Ruggiero, PhD and he can be contacted at 212 523 8260 or Joseph.Ruggiero@mountsinai.org

Client Population (Eligibility, Diagnostic/Clinical Characteristics Demographics): Program Organization (i.e. Staffing):

Clients enter with a primary diagnosis of substance dependency or abuse and have a variety of drug and alcohol problems. Roughly 75% of the clients have co-morbid psychiatric problems such as mood disorders and Axis pathology. They often have additional psychiatric care such as psychiatric day programs, therapists and psychiatrists. Clients come from diverse racial and cultural backgrounds as well as sexual orientations. The staff in the outpatient department include psychologists, social workers, CASACs, master's level counselors, and a half time psychiatrist. The Addiction Institute is part of a training hospital and we also have psychology externs, postdoctoral psychology fellows, social work interns, psychiatric residents, and masters level trainees.

Psychology Intern Role and Responsibilities (including individual therapy, group therapy, family

therapy, assessment, intakes, case management, crisis intervention, community meetings, etc; number of patients/groups, days and hours, etc.):

The Psychology Intern works within the intensive program and co-leads a process group every morning with another professional. The process group has a caseload of up to twelve clients. The intern, along with the professional, will see clients individually as needed. In addition, they do paperwork for the group. Interns co-lead a parenting group and a DBT group with the psychology fellow and co-lead a cognitive behavioral group that focuses on relapse prevention. Interns also run an orientation group for people who are about to be admitted into the day program where they use motivational interviewing to engage the clients. They come to daily rounds at 10:15 after their process group.

Supervision:

Supervision is provided by a licensed psychologist on a weekly basis. In addition, they meet daily with their co-leader to de-brief what happened in group. Supervision consists of assessment and also on treating substance use. This includes working on helping clients identify triggers, managing cravings, helping the client define goals around their use, exploring ambivalence. Supervision also happens throughout the week as needed.

Appendix E

Comprehensive Adolescent Rehabilitation and Education Service (CARES): Handbook

Program Description:

The purpose of the Comprehensive Adolescent Rehabilitation and Education Service (CARES) at St. Luke's and Roosevelt Hospitals is to provide a safe and therapeutic environment for New York City public high school students whose previous school performance has been limited by emotional and behavioral difficulties. CARES provides both educational and therapeutic components, including substance abuse treatment for students who use drugs or alcohol.

The CARES educational component is provided directly by teachers of the New York City Department of Education. All CARES treatment components are designed to address the specific problems that have interfered with each individual student's academic and social success in the past. Students at CARES earn credits towards a Regents Diploma or a Generalized Equivalency Diploma (GED), depending on their academic progress and goals.

While all CARES students share the same educational and treatment resources, CARES is comprised of two tracks, each of which has a specific clinical focus. The Adolescent Alternative Day Program (AADP) track is designed to help students whose school performance has been affected most by problems with social skills, anxiety, and/or mood changes. The word "alternative" in the AADP title refers to the more focused, individualized, small and respectful environment that students are seeking when they apply here from regular high school settings. The Comprehensive Addictions Program for Adolescents (CAPA) track offers additional services for students seeking recovery from substance abuse. CAPA uses a variety of interventions and approaches to help students reduce and ultimately abstain from substance use.

CARES is licensed by the Office of Mental Health as well as the New York State Office of Alcoholism and Substance Abuse Services.

Logistics:

CARES Contact Information:

Roosevelt Hospital Campus
432 West 58th Street, 9th Floor
New York, New York, 10019
Tel: 212-523-7233 (front desk)
Fax: 212-523-7547

Hours of Operation:

CARES provides a year-long combined academic and clinical program that runs on an academic schedule from September through June (8:45am-3:05pm). During most school holidays, CARES tries to offer an abbreviated day of clinical and recreational activities (10:00am-1:00pm). During the summer months (July and August), CARES typically provides summer school classes, continued clinical services, and increased pro-social recreational activities.

Clinical staff is on-site at CARES between the hours of 9:00am and 5:00pm.

Core Program Staff:

1 Director
2 Attending Psychiatrists (1 for AADP team; 1 for CAPA team)
4 Licensed Psychologists
2 Full-time Clinical Social Workers
1 Part-time Clinical Social Worker
1 Substance Abuse Clinician
2 Part-time Creative Arts Therapists
9 Department of Education Staff

Training Staff:

Psychology Post-Doc
Psychology Interns
Psychology Externs
Psychiatry Fellows
Creative Arts Interns
Social Work Interns

Upon arrival at CARES, psychology interns attend a CARES-specific orientation in which important details about the CARES rotation is discussed and detailed handouts are provided. In addition to an overview of the treatment provided at CARES, the orientation includes sessions that focus on the following topics:

- 1 Assessment and treatment of co-occurring mental health and substance use disorders in adolescents
- 2 Dialectical Behavior Therapy (DBT) for adolescents
- 3 CARES Policies (review of CARES student handbook)
- 4 Billing, documentation, admission and discharge procedures
- 5 Treatment planning
- 6 Milieu treatment and review of milieu protocol

Referral and Intake Process

Students are referred to CARES by a variety of sources including schools, treatment providers, inpatient psychiatric units, inpatient/outpatient substance abuse rehabilitation programs, the criminal justice system, the foster care system, community based case management services, preventive agencies, and families and friends of current or former CARES students.

If interested in applying to CARES, the interested party reaches out to the program's intake coordinator and requests a program brochure and application. The referral source and the adolescent are expected to complete the application packet and return to CARES for review. Once the application materials are reviewed, appropriate candidates are scheduled for an education evaluation. If the adolescent meets the required score for admission and his/her academic needs can be met by the CARES education staff, a comprehensive psychiatric intake evaluation is then scheduled. This thorough evaluation (a total of 3 visits including the education evaluation) is conducted by a team of clinicians who then meet to review each applicant and determine a clinical disposition based on the needs of the adolescent and the level of services provided at CARES. Once an applicant is deemed appropriate for enrollment at CARES, a start date is determined and the family is informed of this decision.

Client Population:

CARES services students who are between the ages of 14 and 19 years old, have graduated from the 8th grade, and who have met the educational requirements set forth at intake. They are ethnically, racially, and socio-economically diverse and come from all five NYC boroughs. Students that require the level of psychiatric care provided at CARES must have a Global Assessment Functioning score of 50 or below (identified as Severely Emotionally Disturbed). Aside from this GAF score requirement, there are no other clinical exclusion criteria. Students who attend CARES present with a wide range of psychiatric and/or substance use issues

and their individual treatment plan is developed accordingly.

Overview of Treatment @ CARES:

Treatment at CARES is provided by a multidisciplinary team that is comprised of social workers, psychologists, psychiatrists, substance abuse clinicians, and creative arts therapists. Each student is assigned a primary clinician and psychiatrist who oversee the individual's treatment plan. The CARES clinical staff works as a team to ensure that all aspects of the individual's treatment plan are in place and working effectively.

Types of Clinical Services

Treatment is provided on a daily basis, Monday through Friday, twelve months throughout the year. The therapeutic services provided at CARES include the following:

- 1 Comprehensive, integrated evaluation
- 2 Individual Therapy (min. 1x/week)
- 3 Collateral Sessions (min. 1x/month or as needed)
- 4 Family Therapy (as needed)
- 5 Case Management
- 6 Group Therapy (5 days/week)
- 7 Psychopharmacology (as needed)
- 8 Health Management (as needed)
- 9 Milieu Therapy (daily)
- 10 Crisis Intervention (as needed)
- 11 Complex Care Management (as needed)
- 12 Public high school academic services (for diploma or GED)
- 13 Community Meetings
- 14 Complementary Services (ex: linkages with community organizations, AA/NA meetings, after-school activities)
- 15 Breakfast, Snacks, and Lunch

Evidence-Based Treatment Models

Two major components of the CARES treatment model include Dialectical Behavior Therapy (DBT) and the Transtheoretical Model of Stages of Change. DBT is a highly effective treatment method for teenagers who wish to change from dangerous or self-defeating behavior patterns to more successful responses to stress. Each student is assigned to a DBT group that meets twice a week. Additionally, students practice these skills with their individual therapist and with clinicians on the milieu. The Transtheoretical Model of Stages of Change, based on the research of Prochaska and DiClemente, shows how people successfully make changes in their lives. Students learn about the five distinct stages of change (precontemplation, contemplation, preparation, action, maintenance), how to identify their current stage, and develop an understanding of how this model influences their treatment planning and interventions.

In addition to DBT, other treatment approaches that are used by the staff include motivational interviewing, trauma focused treatment, cognitive behavioral therapy, and psychodynamic psychotherapy. Supervision and consultation using these theoretical perspectives is readily available to all trainees.

Psychology interns are invaluable members of the CARES clinical team. The internship experience at CARES is rich with a variety of training opportunities and clinical responsibilities. In addition to being assigned 1-2 individual clients, psychology interns co-lead group therapy, provide milieu therapy and crisis intervention, and actively participate in daily morning rounds, weekly clinical team meetings, DBT consultation teams, and supervision (individual and systems).

Treatment Modalities

Below are descriptions of the various treatment modalities provided at CARES, and the role of the psychology intern with each of these modalities.

Individual and Family Therapy

Students are assigned an individual therapist and a psychiatrist, who will keep track of weekly progress and will meet regularly with students, families, and outside case management or preventive service providers. Therapists help students focus on treatment needs in order to target personal emotional, behavioral, academic, family, and substance use goals. Each student has an individualized treatment plan with realistic clinical and educational goals. Once treatment goals are established, a student and his or her therapist will monitor progress via weekly sessions, diary cards, behavior analysis, and other assessment tools. Students in the CAPA track are also expected to donate urine each week and discuss results with their individual therapist. Treatment plans are reviewed and revised every three months by the student and his or her therapist, psychiatrist, and family. Therapists also meet with each student and his or her family on a monthly basis to review progress and areas for improvement.

Case management services are often deemed necessary for students attending CARES. If a student does not have case management services, it is likely that the student's individual therapist will refer the student and his or her family for services through C-SPOA (Child Single Point of Access).

As a primary therapist for 1-2 CARES cases, psychology interns will meet weekly with their client(s), work with the family and collateral providers as often as needed, consultation with education staff as needed, and maintain up-to-date progress notes, treatment plans, and any other documentation that is required for comprehensive client care.

Group Therapy

Like school classes, group therapy sessions are an essential part of the daily therapeutic curriculum at CARES. We offer several kinds of groups including motivation enhancement, DBT skills and consultation, healthy living and wellness, social skills, music and art therapies, trauma informed treatment, and strategies for transitioning. Students for whom drug or alcohol use is an issue will also be assigned to regular substance abuse recovery or relapse prevention groups.

Psychology interns are assigned to co-lead with a licensed clinician, three groups per week. Supervision of group therapy (1 hour) is offered weekly.

Psychopharmacology/Medication Management

All CARES students are evaluated by a psychiatrist for their medication needs. They must meet with their assigned psychiatrist on a regular basis. Any changes to medication must be discussed with their psychiatrist beforehand. Psychiatrists are also available for any salient medical issues that may arise during the day.

As a primary therapist at CARES, psychology interns and psychiatrists meet frequently (in weekly AADP/CAPA team meetings; DBT consultation meetings; and on an as-needed basis) to consult about different cases and to discuss and carryout the appropriate course of treatment for the client.

Milieu Therapy

Each day, at least two clinical milieu staff members, including psychology trainees, monitor the community space. Milieu staff is available throughout the day for brief counseling, to answer any questions students have about the program, to help reinforce program rules and offer an opportunity for skills coaching and practice. The milieu staff schedule is posted throughout the floor so students can easily determine who to go to each day for assistance. Milieu staff is instrumental in assisting students and educational staff in times of distress. Milieu staff will typically work outside of the classroom. However, when appropriate they will follow a school consultation model and join teachers in the classroom, implementing behavioral interventions within the classroom that are based on the patient's individualized clinical treatment plan. Students needing assistance will be directed to milieu staff or their therapist, and may be required to complete a modified version of a

behavioral analysis or other de-escalation approaches before returning to class or community areas. Students are expected to follow directions and work with milieu staff. In order to ensure a safe environment, physical and verbal aggression, bullying, and other provocative behaviors are not tolerated in the CARES community. In response to past student council requests, and to further ensure the safety of students and the community, staff periodically conducts random and targeted searches of students.

Given our students' complex needs they have the opportunity to ask for a five minute break from class in order to speak with milieu staff to address treatment needs or pressing issues. Students struggling to remain appropriately in class may be asked by their teacher to "take a five" and work with milieu on re-entering the classroom environment. The seamless collaboration between clinical and educational staff on the milieu enables students to remain successful in the community while working through difficulties.

Psychology interns spend at least 2 hours on milieu, providing the services and support described above.

Psychology Interns CARES Schedule

Psychology interns are present at CARES approximately 12 hours per week. During this time, interns are expected to:

- 1 Attend morning rounds (9am-9:30am each morning)
- 2 Participate in weekly team meetings (AADP: Tuesday 9:30am-10:30am; CAPA: Thursday 9:30am-10:30am)
- 3 Meet with individual client(s) at least 1x/week (45 mins)
- 4 Co-lead group therapy 3x/week (10:30am-11:30am)
- 5 Attend individual supervision 1 hour per week
- 6 Attend group/systems supervision (Friday 2:00pm-3:00pm)
- 7 Attend DBT consultation team meetings (Friday 4:00pm-5:00pm)

The DBT consultation teams (multidisciplinary) provide an opportunity to discuss cases and crises, get support from other team members, and learn to conceptualize cases from a variety of clinical perspectives. Once per month, all DBT consultation teams are combined and Education staff are invited to join for a Large Group DBT Consultation Team to review and process program and systems issues.

Given the multidisciplinary nature of the CARES team, interns have numerous opportunities throughout the week to seek out consultation from peers, supervisors, psychiatrists, or educational staff. This ongoing supervision and consultation allows the intern to continually sharpen their clinical skills and develop a comprehensive perspective of how treatment can be provided to clients in this setting.

Appendix F

Mount Sinai St. Luke's-West

Psychological Assessment Handbook for Interns

2019 - 2020 Training Year

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Testing Supervisors' Contact Information

Andrea Fortunato Loftus, Ph.D.

Head of Assessment Training and Education

411 West 114th St

New York, NY

Email: Leora.Heckelman@mountsinai.org

Phone: (215) 872-3028

Claudia Diez, Ph.D.

200 West 57th Street, Suite 1310

New York, NY 10019

Email: info@drclaudiadiez.com

Phone: (212) 744-8073

Karen Merns, Ph.D.

411 West 114th Street

New York, NY

Email: Karen.Merns@mountsinai.org

Phone: (917) 334-8636

Anthony DeMaria, Ph.D.

411 West 114th Street

New York, NY

Email: Anthony.Demaria@mountsinai.org

Phone: (646) 574-9743

APA Requirements for Psychological Assessment on Internship

For each intern to meet the requirements for psychological assessment as part of their internship year, they must administer two integrated batteries, reports to be completed by July 01, 2020. If a student has an interest in receiving more than two testing cases during their internship year, there may be opportunities for additional experiences.

You may receive a testing assignment while on rotation (e.g., CITPD, inpatient, Addiction Institute) or from the Outpatient Psychiatric Clinic. Thus, requirements for testing may differ according to the setting and the nature of the referral.

Neuropsychological assessment cases may be available, depending on supervisor and student expertise.

Location of Physical Testing Materials

The testing center is located on the 6th floor of OPC in Suite 6C, first room on the right. There is a sign-up sheet on the door if you would like to book time in the room.

In the testing center you can find the following materials in filing cabinets.

SELF-REPORT MEASURES / MEASURES ON PAPER:

Drawer 1

- CAADID + photocopies
- Comprehensive Test of Nonverbal Intelligence (CTONI) – Record forms
- Boston Diagnostic Aphasia Examination Booklet – one copy
- ABAS-2 + photocopies – NEWST VERSION is ABAS-3; order placed with Jackie
- BBI
- BSI + photocopies
- Career Assessment Inventory
- BPI – Borderline Personality Inventory
- Cultural Evaluation
- Dementia Rating Scale – II
- GADS – Gilliam Aspergers Disorder Scale
- House-Tree-Person
- Inventory of Drinking Situations – IDS-100
- CELF-4 Observational Rating Scale
- NEPSY-II
- Structured Interview of Reported Symptoms (SIRS)
- M-FAST
- MBMD

- MINI – International Psychiatric Interview
- MMPI-II (English and Spanish + photocopies)
- ANQ (Spanish)
- Myers-Briggs
- MDQ
- MOCA
- MSCEIT
- MMSE
- MSVT – Medical Symptom Validity Test

Drawer 2 –

- NEO + photocopies
- Hare PCL-R
- RISB
- SASSI
- SCID-I
- SCID-II
- SCL-90
- SIFFM
- PHQ
- Situational Confidence Questionnaire – SCQ-39
- STAXI
- Suicide Risk Assessment
- URICA
- TAT

Drawer 3 –

- RBANS (English and Spanish)
- REY-15

- PAI (English and Spanish)
- Rorschach Structural Summary (EXNER)
- ROTTER Incomplete Sentence Manual
- Manual for the Strong Interest Inventory

Drawer 4 –

- Neuropsych Intake Interview (English and Spanish)
- Dean-Woodcock Sensory Motor Battery
- Mental Status Exam (Spanish)
- National Depression Screening Day (Spanish)
- BIA (Spanish)
- Vineland-II
- WMS-IV – record form and response booklet for older adults
- **NEED TO ORDER WMS-IV FOR ADULTS**
- WAIS-IV + photocopies
- WISC-IV
- WASI
- WRAT-IV-Blue and Green Response Forms
- Y-BOCS

TESTING KITS:

Neuropsychological Tests

- Wisconsin Card Sorting Test
- Bender-Gestalt-II
- D-KEFS

Personality Tests

- Rorschach Cards
- TAT cards ~ 3 sets

Achievement Tests

- WRAT-4 Instrument
- BATERIA-III
- CTONI-II

Cognitive Tests

- WAIS –IV kit
- Test of Nonverbal Intelligence kit
- WMS-IV kit

If you remove any of these items from the testing center to administer an assessment in another location, please **sign out** what you're taking on the Google Doc:

https://docs.google.com/spreadsheets/d/1ipjdlm66P4JYB3p_B7BSFBhAdOC5AGKiQzyI526wSQY/edit#gid=0

Passwords for Online Administration and Scoring

****Please note that passwords are case-sensitive

Q-Global:

<https://qglobal.pearsonclinical.com/qg/login.seam>

User ID: mshpsych

Password: Intern21!

Q-Global provides access to on-screen administration and scoring of tests published by Pearson Clinical, including:

- MMPI-2-RF
- MMPI-A
- MCMI-IV

R-PAS:

<https://www.r-pas.org/Login.aspx>

User ID: MSSLW

Password: Exner

This site provides scoring protocols for the Rorschach Inkblot Test as administered via Performance Assessment System (R-PAS). Here you can also access administration and coding video tutorials, an electronic R-PAS manual, as well as a library system where you can request R-PAS-related articles.

PAI:

User ID:

Password:

PARiConnect provides access to on-screen administration and scoring of the Personality Assessment Inventory (PAI), which is published by Psychology Assessment Resources, Inc. (PAR).

Instructions for Q-Global Administration:

Desktop On-Screen Administration:

Select this option if you want to administer an assessment locally on a PC or Mac.

Note: This option is available for Pearson CPT administration.

Manual Entry:

Select this option if you want to administer an assessment on paper and then transfer the responses to Q-global via manual entry. All Q-global assessments have a manual entry option.

On-Screen Administration: (with Test Session Lock)

Download Test Session Lock Select this option if you want to administer an assessment on a web-enabled computer AND lock the testing session to prevent the examinee from exiting the assessment. This option requires that a program file be installed on the computer (PC/Mac) and will require administrative permission/rights.

This option is recommended for examiners who want to restrict an examinee from accessing an internet browser, programs or files stored on the computer.

Note: This option is not available for mobile devices, including tablets, and is not intended to replace a proctor for those assessments requiring supervision during an administration.

We strongly recommend using Chrome, Firefox or Safari.

On-Screen Administration: (without Session Lock)

Select this option if you want to administer an assessment on the computer screen via any web-enabled device. This option does not lock the testing session to prevent the examinee from exiting the assessment.

This option may be useful in settings where strict control of examinee access to the internet is not required, sensitive programs and/or files are not stored on the computer/device, and in settings that do not allow users to install applications/files to the computer/device that is being used for the test administration.

Remote On-Screen Administration:

Select this option if you want to administer an assessment by sending an email with a secure link to the examinee/rater who will then complete the assessment via their own web-enabled device.

This option is recommended for examiners who would like to send an online assessment form to remote examinees or raters. This feature is only available for select Q-global assessments that do not require a high level of test security and supervision during administration. This option does not include a Test Session Lock feature.

Testing Report Format

Please use the following template for your testing reports (with any adjustments/additions made according to the preferences of your individual testing supervisors):

Psychological Assessment

Patient Name:

Patient Date of Birth:

Dates of Evaluation:

Patient Age at Evaluation:

Date of Report:

Reason for Referral

Include referral source.

Tests Administered

List here

Sources of Information

List here

Medications

List here

History of Presenting Illness

Include any known dx and treatment hx; make sure to mention any hospitalizations, prior testing, etc.

Developmental/Psychosocial History

Born & raised where, by whom; educational hx; past and current social life, romantic relationships, children; etc.

Legal History

If applicable

Medical History

If applicable

Collateral Contacts

If applicable

Behavioral Observations/Approach to Testing

What was it like to be in the room with the patient; did they complete all tests; what was their behavior during interview/testing; did they appear to struggle significantly with any task; any other observations you made related to behavioral aspects of mental status.

TEST RESULTS & INTERPRETATION

Cognitive Functioning: Intellectual Ability

E.g. WAIS-IV

Cognitive Functioning: Memory

E.g. WMS-IV

Personality Functioning: Self-Report

E.g. MMPI-2-RF, MCMI-IV, PAI, etc.

Personality Functioning: Projectives

E.g. TAT, ROR

IMPRESSIONS AND TREATMENT RECOMMENDATIONS

Summarize your findings across different tests; treatment recommendations can be put in a numbered list.

(signatures below)

Your Name

Psychology Intern

Mount Sinai St. Luke's-West Hospitals

Your Supervisor's Name

Supervising Psychologist

Suggested Reading List

- Blumenfeld, H. (2010) *Neuroanatomy through clinical cases, second edition*. Sunderland: Sinauer Associates.
- Exner, J. E., & Colligan, S. C. (2001). *A Rorschach workbook for the Comprehensive System*. Asheville, NC: Rorschach Workshops.
- Finn, S. E. (2016). *In our clients' shoes: Theory and techniques of therapeutic assessment*. New York: Routledge.
- Greene, R. L. (2011). *The MMPI-2/MMPI-2-RF: An interpretive manual (3rd edition)*. New York: Allyn & Bacon.
- Grossman, S. & Amendolace, B. (2017). *Essentials of MCMI-IV Assessment*. Hoboken, NJ: Wiley.
- Gurley, J. R. (2016). *Essentials of Rorschach Assessment: Comprehensive System and R-PAS*. John Wiley & Sons.
- Meyer, G. J. (2017). *Using the Rorschach Performance Assessment System (R-PAS)*. Guilford Publications.
- Strauss, E., Sherman, E., Spreen, O. (2006). *A Compendium of Neuropsychological Tests -3rd Edition*. New York: Oxford University Press.
- Teglasi, H. (2010). *Essentials of TAT and other storytelling assessments (Vol. 64)*. John Wiley & Sons.
- Yeates, KO., Ris, MD., Taylor, GH., Pennington, BF (2010). *Pediatric Neuropsychology, Second Edition: Research, Theory, and Practice*. New York: The Guilford Press.

Appendix A: Testing Referral Form

Mount Sinai St. Luke's-West Hospital

Psychological Testing – Referral Form

Email to:

Leora.Heckelman@mountsinai.org

Patient Name:

Referring Clinician:

D.O.B.:

Age:

Program/Clinic:

Gender:

Referral Date:

Language:

Needs translator?

Highest level of education:

DSM-5 Diagnoses:

Substance Use Hx:

Date of Last Use:

Date of Last Use:

Date of Last Use:

Hx of TBI?

Learning difficulties?

Hx of inpatient hospitalization?

Safety concerns/Risk factors:

Patient has had previous psych testing?

If so, explain:

Insurance:

Best way to contact Patient:

Best days/times for appointments:

Specific Referral Questions: (Example: *What are the Pt's cognitive abilities, strengths, and weaknesses? Is there personality pathology? What is the Pt's personality functioning? Are there signs of a dementia process?*)

1.

2.

3.

Testing Requested: (Example: *Cognitive evaluation; Learning disability; Full diagnostic assessment*)

Leave blank if unknown

Patient's level of motivation for assessment:

Suggestions, Comments, Concerns:

Testing referral approved by:	Date approved:
Referral assigned to:	

TO COMPLETE AFTER TESTING PROCEDURE BY SUPERVISOR/EXAMINER:	
Testing dates:	CPT codes:
Reports date:	
_____	_____
Examiner Signature & Title	Date
_____	_____
Supervisor Signature & Title	Date

Appendix B: Syllabi from Testing Didactics

Psychology Intern (Adult and Child) Core Competency Course

Psychological Assessment

MMPI-2-RF and MCMI-IV

Andrea Fortunato Loftus, Ph.D.

This series of lectures will familiarize interns with two well-researched and widely used self-report measures for psychopathology and personality functioning, the MCMI-IV and the MMPI-2/RF. First, a review of theoretical basis for each measure will be provided. Interns will learn how to determine when to utilize MCMI-IV versus or alongside of MMPI-2/RF in a testing battery in order to answer the testing referral questions. We will discuss how the MMPI-2 was restructured and what are each of the substantive components identified from MMPI-2 clinical scales for the restructured form of the measure. Millon's evolutionary theory and motivating aims of personality will be discussed. We will also briefly discuss how MMPI-2/RF and MCMI-IV can be used for therapeutic assessment, i.e. helping patients to formulate some of their own questions about themselves that can be answered through the psychological assessment.

Principles of ethical and reliable test administration of self-report personality measures as will also be presented. We will discuss common test administration issues that arise when carrying out psychological assessment in different hospital settings, e.g. clinic versus inpatient. We will review when to utilize measures for adolescents versus adults when the patient is 18 y/o and discuss prior experiences interns have had in hospital clinics (such as CARES program) where these issues come up. We will discuss administration procedures for vision-impaired patients. Procedures for administration via Q-Global platform versus pen/paper administration will be discussed. Interns will also learn how to evaluate and manage issues of safety that arise during the process of test administration.

Review of assessment concepts such as raw score, base rate, T-score, and percentile rank will be provided. Interns will gain familiarity with each scale of these measures and practice evaluating score validity together in-class using de-identified score reports from prior hospital testing cases. We will discuss how invalid score reports provide clinically useful information. We will also address how substance use and intoxication should be taken into consideration when evaluating a patient's score report.

This lecture will also review how to interpret the MCMI-IV and MMPI-2/RF together and how to present findings from these measures in both written reports as well as oral presentation in psychiatry rounds and team meetings/consultations. Finally, interns will be encouraged to critically consider how these measures converge/diverge with the DSM-5 Section III emerging model for personality functioning. Time will also be provided at the end of each lecture for some brief discussion of interns' ongoing testing cases.

References

Greene, R. L. (2011). *The MMPI-2/MMPI-2-RF: An interpretive manual (3rd edition)*. New York: Allyn & Bacon.

Grossman, S. & Amendolace, B. (2017). *Essentials of MCMI-IV Assessment*. Hoboken, NJ: Wiley.

Recommended:

Finn, S. E. (2016). *In our clients' shoes: Theory and techniques of therapeutic assessment*. New York: Routledge.

Psychological Assessment Using Projective Measures Syllabus

Instructor: Anthony P. DeMaria, Ph.D.

Objectives: This lecture series aims to provide trainees with information and skills needed to effectively administer and interpret projective personality measures when conducting psychological assessments. Trainees will be exposed to the history and relevant research on projective measures. Trainees will then discuss nuances of administration and interpretation of the TAT, and Rorschach using both the Comprehensive System and R-PAS.

Schedule

Week 1: Overview

Week 2: Rorschach CS

Week 3: Rorschach R-PAS

Week 4: TAT

References

Exner's A Rorschach Workbook for the Comprehensive System

Gurley's Essentials of Rorschach Assessment: Comprehensive System and R-PAS

Mihura and Meyer's Using the Rorschach Performance Assessment System

Teglasi's Essentials of TAT and Other Storytelling Assessments

Jodi Uderman's Courses:

A lifespan neuropsychological assessment unit was introduced across 2 lectures. The lectures covered topics including: goals of neuropsychological assessment, common referral questions across the lifespan, evidence based neuropsychology practice, major neuropsychological theories (i.e., cerebral localization vs. generalist), and a review of cognitive and neuropsychiatric domains assessed. The unit also included a case presentation, which highlighted aforementioned topics and integrated clinical neuroanatomy in an interactive, discussion-based format.

References:

Yeates, KO., Ris, MD., Taylor, GH., Pennington, BF (2010). *Pediatric Neuropsychology, Second Edition: Research, Theory, and Practice*. New York: The Guilford Press

Strauss, E., Sherman, E., Spreen, O. (2006) *A Compendium of Neuropsychological Tests - 3rd Edition*. New York: Oxford University Press

Blumenfeld, H. (2010) *Neuroanatomy through clinical cases, second edition*. Sunderland: Sinauer Associates

Appendix G

Mount Sinai St. Luke's-West

Neuropsychological Assessment Handbook for Interns

Child Track

2019 - 2020 Training Year

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Contact Information

Jodi Uderman, Ph.D.
Clinical Neuropsychologist

Address:
411 West 114th St.
5th Floor
New York, NY 10025

Email: Jodi.Uderman@mountsinai.org

Phone: 212-523-5578

Requirements for Assessment during Internship Year

1. Each intern will have an assigned testing rotation for approximately 3 months. During this time, the intern will have reserved time on Monday and Friday mornings for assessments, scoring, report writing, and supplemental supervision. Thursdays from 2:15-3:15 pm will also be reserved for set weekly supervision during the intern's assigned rotation.
2. During the 3 month testing rotation, each Child Track intern is required to complete two supervised assessments, consisting of at least two different measures of neuropsychological, psychological, and/or psychoeducational functions. Interns will also engage in supervised scoring, report writing, and feedback sessions.
3. Interns will attend assessment didactics course (see next page)

Assessment Didactics Courses

**Child Psychology Internship
Neuropsychological Evaluation
Summer 2018 Course Syllabus
Wednesdays 2:15 – 3:15 PM, 411, 5th Floor**

07/12/2018	Evidence Based Practice of Pediatric Neuropsychology
07/19/2018	Evaluation procedures at CFI: referral process, insurance, session structure, documentation, supervision, reports, feedback, advocacy, and collaboration/consultation
07/26/2018	No meeting
08/02/2018	Measures: Intelligence and achievement
08/09/2018	Measures: Attention/Executive functions
08/16/2018	Measures: Language and visuospatial
08/23/2018	Measures: Sensorimotor and memory
08/30/2018	Measures: Social, emotional, and personality

**Child/Adult Core course 2018
Mondays 12:45- 1:45 PM, 1090
16th floor conference room**

8/20/2018	Introduction to Lifespan Neuropsychology
8/20/2018	Case Presentation

Evaluation Procedures

1. Case assigned to trainee by supervisor
2. Contact referring clinician & review chart in TIER to get referral questions/concerns
3. Trainee will contact family and schedule an intake session to get additional history from family and provide psychoeducation about the evaluation (supervisor present)
 - a. Send an intake packet to family or give to referring clinician prior to intake
4. After intake: write history section of report and review in supervision
5. Obtain prior authorization if needed (see below)
6. Schedule 1-2 evaluation sessions (2-4 hours each on Monday and/or Friday mornings)
7. Score measures between evaluation sessions
8. Complete report
9. Schedule feedback with family

**Email entire treatment team and cc supervisor whenever appointments are scheduled

Supervision

1. **Before intake:** Be prepared to present referral information and background from review of medical and academic records.
2. **After intake:** Write pt's history and send to supervisor for review
3. **After each testing session:** score everything in preparation for supervision and write it out in a test data summary (TDS). Send TDS to supervisor before supervision along with any score reports.
4. **After testing is complete:** meet with your supervisor to discuss conceptualization and diagnostic impressions. Discuss timeline for report writing.
5. **After each draft:** You will receive feedback on your reports via track changes/comments. These will be reviewed in supervision.
 1. Please proofread your report. Your supervisor is here to help you with the content of your writing and conceptualization of your case, not to serve as your editor.
6. **After report is complete:** scan into TIER and send copies to treatment team and family
 1. Give chart with raw data to supervisor. Scan chart in order of TDS template and send to supervisor.

Insurance procedures

1. Prior to scheduling, verify pt insurance by emailing PSRs. Information reflected in TIER is not always correct. Verify if managed Medicaid or straight Medicaid/ SSI
2. Almost all managed Medicaid insurance carriers require prior authorization for testing. Each company has different procedures. Call the respective carrier to gather the following information:
 - a. Does the patient require pre-authorization for psychological or neuropsychological testing? (CPT codes 96116, 96121, 96132, 96133, 96136, 96137, 96130, 96131)
 - b. If pre-auth is required, which insurance specifically requires it? (i.e., Medicaid, the main insurance and/or which faction of the main insurance, in a case like beacon which has many different options).
 - c. What is required for the pre-auth? A specific form? A phone call? Faxing in clinical notes from the chart? If a form or notes need to be faxed in, does a call need to be placed first to open the auth? Etc.
 - d. How does the above info get submitted? Please indicate phone and/or fax numbers or website portal information
 - e. What number is best to use when I need to follow up about the status of the approval/denial
3. When calling insurance companies, have the following information ready:
 - a. Your basic contact info: phone and fax
 - b. Pt information (name, DOB, insurance #)
 - c. MSSL Tax ID and NPI
 - d. The number of units you require for testing
 - e. The CPT code you plan to use
 - f. Diagnosis code: typically for neuropsych use R41.9
4. In addition to the above information, most pre-auths require info such as:
 - a. Presenting symptoms/complaints
 - b. How symptoms are impacting functioning
 - c. Why is testing necessary/How will testing help (often includes what's been done in the past and why that was not enough)
5. Review all clinical information with supervisor prior to submitting
 - a. Insurance companies will not authorize psychoeducational testing or referral questions that are exclusive to learning difficulties or ADHD. You should emphasize any developmental, medical, or psychiatric symptoms that are part of the referral question and how they will impact evidence based treatment within the clinic (*not school*).

6. If the authorization request is approved, add all information in TIER financial section: authorization number, # units, dates, CPT and diagnosis codes. Email all of this information to your supervisor. Send any documentation to PSRs.
7. If the authorization is denied, you will, in most cases, be given the opportunity to appeal, should you disagree with the rationale.
 - a. The appeal process will typically require additional clinical documentation re: reason for referral and history of presenting problem.

Location of Testing Center and Materials

- The testing center is located on the 5th floor, Suite 5C conference room, of the 411 W. 114th Street building, where the Child and Family Institute Outpatient Department (CFI OPD) is located. The conference room is reserved by emailing Deborah Chinn (Deborah.Chin@mountsinai.org)
- All test materials are located in the adjacent testing closet. The closet can be opened with the "E" key. If you have not received one during orientation, please contact Deborah Chinn to sign out the key as needed.
- There is a sign-up sheet on the door of the testing closet if you need to use any testing materials/take them out of the testing center. All materials are to be returned immediately after using. If materials are needed outside of your assigned testing rotation, please also email testing supervisor (jodi.uderman@mountsinai.org) so that there is appropriate coordination among evaluators.

In the testing closet you can find the following materials:

- Stopwatch
- WISC-V
- WASI-II
- WAIS-IV
- PPVT-4
- Woodcock Johnson test of achievement-IV
- Woodcock Johnson test of cognitive abilities-III
- TOWL-4
- Gort-5
- Nelson Denny
- WRAML-2
- NEPSY-II (2 copies)
- DKEFS
- WCST-64

- CPT-III (USB stick)
- Teach-2
- Grooved pegboard
- CELF-V
- Boston Naming Test (2 copies)
- Test of Language competence (TLC)
- Rey complex figure task (RCFT)
- Hooper (HVOT)
- Beery-VMI
- Sentence completion
- Rorschach
- TAT

There are also many symptom inventories and other rating scales available, including:

- BASC-3
- MMPI-A-2RF
- MMPI-RF
- Vineland-III
- BRIEF
- KSADS
- Beck youth inventory
- CARS
- Vanderbilt
- SNAP
- SCARED
- Edinburgh handedness inventory
- ASRS (USB stick)
- ADIR
- PBQ
- SCQ
- CYBOC

Passwords for Online Administration and Scoring

****Please note that passwords are case-sensitive

Q-Global: MMPI, BASC-3

<https://qglobal.pearsonclinical.com/qg/login.seam>

User ID: Please see Dr. Uderman or paper copy of handbook for this information

Password: Please see Dr. Uderman or paper copy of handbook for this information

Woodcock Johnson-IV

<https://www.wjscore.com/WJIV>

Dr. Uderman will provide you with individual log-in information

MHS: USB sticks are located in the testing closet: ASRS, CPT-III

Username/password for CPT-III: MHS/MHS

Suggested References

Yeates, KO., Ris, MD., Taylor, GH., Pennington, BF (2010). *Pediatric Neuropsychology, Second Edition: Research, Theory, and Practice*. New York: The Guilford Press

Strauss, E., Sherman, E., Spreen, O. (2006) *A Compendium of Neuropsychological Tests -3rd Edition*. New York: Oxford University Press

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