Indian
HEALTH BOARD

COMMUNITY TRADITION WELLNESS

TRAINING MANUAL

2020-2021

APA Accredited Doctoral Psychology Internship Training Program

Indian Health Board of Minneapolis, Inc.
Counseling & Support Clinic
1315 East 24th Street
Minneapolis, MN 55404

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Note: This manual is intended to provide helpful information that is specific to trainees at the Indian Health Board Counseling & Support Clinic. Overall clinic guidelines, policies, and procedures are located in the Principles of Practice Manual and Employee Handbook.

All trainees are required to read the C&S Principles of Practice Manual and the IHB Employee Handbook as well as this Training Manual*.*

Dear Trainees:

Welcome to the Counseling & Support Clinic of the Indian Health Board of Minneapolis, Inc. We are glad you are a part of our program for the next 12 months and know that we will all learn many things from each other over the next year!

We have had advanced psychology training for practica trainees and doctoral psychology interns since 1992, became part of an APPIC-Approved Consortium with Washburn Child Guidance Clinic from 2000-2006, and an independent APPIC-Approved training site for 2006-2007. We added a postdoctoral fellowship in 2004 and received postdoctoral APPIC membership in May 2009. We received American Psychological Association (APA) accreditation in November 2015 with re-accreditation review occurring in 2022. We have worked diligently to meet the needs of our trainees, while staying faithful to our community-oriented service and Indigenous frameworks during the COVID-19 pandemic, taking care to protect the health of our community – mentally, spiritually, emotionally and physically. We are currently only offering virtual and telehealth services and will be developing a virtual internship interview process for the 2021-2022 training year.

Historically, The Indian Health Board, or IHB, has been an important service provider to the urban American Indian population and other local residents in need since 1971, and began providing mental health services with the C&S Clinic in the early 1990s. A major goal of our training program is to equip emerging mental health professionals with the highest quality skills for addressing the health disparities and mental health needs of the American Indian community in a culturally sensitive and proficient way.

The C&S staff works in a highly collaborative fashion, and this extends to our training program as well. You will have many opportunities to learn and practice various skills and will be exposed to a variety of challenging mental health conditions. When in doubt or feeling overwhelmed, consultation and supervision are key. Also, take advantage of the many occasions to learn about the cultures of our clients, including consultation with staff, participating in or observing cultural events and activities, and learning more about your own culture.

Enjoy your year,

Michael L. Harris, MA, LP, SEP
Director, C&S Clinic

Kyle Hill, PhD, LP
Training Director

TRAINING SITE

Indian Health Board of Minneapolis, Inc. (IHB) is a nonprofit, culturally specific health care agency that provides medical, dental, mental and chemical health services to children, adolescents, and adults. According to 2013-2014 statistics, 48% of IHB clients identify as Native American, 35% identify as Caucasian, 15% identify as African American, and the remaining 2% identify as Asian, Native Hawaiian, or other. 25% of IHB clients overall also identify as having Latino ancestry. Within the Counseling & Support Clinic, 79% of clients identify as Native American, 11% identify as Caucasian, 8% identify as African American, and 2% identify as Asian or other, with 4% of clients overall also identifying Latino ancestry. Notably, the vast majority of clients seen at IHB and within the Counseling & Support Clinic identify as having mixed ethnic backgrounds. In the Counseling & Support Clinic, 63% of clients identify as female and 37% identify as male, though within these categories there are clients who identify as transgender and/or two spirit. Clients currently seen in the Counseling & Support Clinic range in age from four to 88 years old and identify with a variety of religious and spiritual orientations. Clients seen in the clinic also identify with diverse sexual orientations, including heterosexual, two spirit, gay, lesbian, bisexual, and queer. Socioeconomic status varies considerably between clients, though a large portion of the client population served fall below the poverty line.

Clients seen for counseling at IHB present with a wide array of concerns, including posttraumatic stress disorder, intergenerational and complex trauma, interpersonal difficulties, depression, anxiety, self-injury, suicidality, adjustment issues, parenting difficulties, identity development, domestic violence, history of abuse, substance abuse, eating disorders, and grief. Clients also present with diverse disability statuses, including physical, congenital, developmental, and acquired disabilities. Thus, the training program at IHB offers interns in-depth experience with a range of client populations and intersectional identities. Individual and family therapy, group therapy, child and adult assessment, chemical health assessments, social work, and psychiatric services are provided on-site. The department participates with the IHB Medical Clinic in a collaborative effort to reduce health disparities, and opportunities for consultation with Medical Clinic providers are also available. The department also prides itself on training students in cultural proficiency skills aimed toward the urban American Indian community. Indian Health Board of Minneapolis has trained practica students and doctoral psychology interns since 1993, participated in the Urban Child and Family Consortium (UCFC) from 2000-2006, and added a postdoctoral fellow program in 2004. The doctoral psychology internship received APPIC membership in 2000 and APA accreditation in 2015. The postdoctoral residency received APPIC membership in 2009. The agency provides trainees with a wealth of diverse clinical experiences and training opportunities, including urban outpatient treatment, psychological evaluations, collaborative opportunities with culturally specific schools and other agencies, and topic- or diagnosis-specific group therapy. Many interdisciplinary resources are available to interns, both onsite and in collaboration with other agencies and organizations. Staff is committed to working with urban and culturally diverse children and families, with specialized focus and services on the urban American Indian community.
The Indian Health Board of Minneapolis, Inc. complies with guidelines put forth by the Association for Psychology Postdoctoral and Internship Centers (APPIC) and American Psychological Association (APA).

INDIAN HEALTH BOARD MISSION, VALUES AND POLICIES

MISSION STATEMENT

To ensure access to quality health care services for American Indian and other peoples and to promote health education and wellness.

VALUES

Respect for Culture
Excellence
Leadership

VISION

The patients of IHB reach the highest level of health and wellness available, incorporating traditional, culturally correct practices with the best available scientific medical knowledge. They receive the support and commitment of a staff dedicated to patient's success, trained in the skills necessary, and committed to the mission of IHB. Widely known and valued in its community, the Indian Health Board is known as the best place for persons seeking health and wellness, and the best place in the industry to work.

PHILOSOPHY AND MISSION OF TRAINING

The Indian Health Board's guiding philosophy regarding training is to equip developing psychology professionals with the skills needed to serve the diverse and complex mental health needs of the urban American Indian community and others in need in our surrounding urban neighborhoods, as well as rural or reservation-based communities. Because of this focus, which ultimately serves to reduce and eliminate health disparities within the American Indian community, we provide diverse and comprehensive training opportunities to all trainees, including our doctoral psychology interns. Training opportunities draw upon the wealth of programs offered at IHB and also with community partners. Indian Health Board is invested in high quality training, and frequently staff will present training seminars in their particular area of expertise. Additionally, we invite American Indian community members and professionals to present cultural trainings once per month to gain perspective and understanding from the community's point of view. On occasion, cultural opportunities are often available for trainees to observe and/or participate in, such as beading, ribbon skirt making, star quilt making, moon ceremonies and sweat lodges. Trainees consult and collaborate with a range of team members and community providers, including psychiatrists, social workers, psychologists, occupational therapists, case managers, school staff, and county workers. Doctoral psychology interns also may have an opportunity to supervise other developing professionals.

Indigenous Mentorship Model: Training Model for Psychology Internship

Our philosophy of training in the Doctoral Psychology Internship (*Niigimowinmiiwinzha*) at the Indian Health Board emerges from four Indigenous points of view: Lived experiences of the local American Indian community we serve; Clinical experiences of our providers and other professional allies; Literature on Indigenous pedagogy and curriculum; and Cultural insight and guidance of our American Indian elders.

We call the training model that derives from this philosophy the Indigenous Mentorship Model, and we use this model because it incorporates the values of *good relationships* and *interrelatedness*.

Teaching and learning are most effective in the context of *good relationships*, expressed as *Da Ya Unk Unpí* (Dakota) and *Mino-Inawendiwin* (Ojibwe) in the languages of the people Indigenous to the territory we serve. The Indigenous words have the added connotation of 'working well together for the good,' which means that we each have gifts and wisdom to offer and share within the community, making us all teachers and students simultaneously.

We strongly hold that teaching and learning are inseparable from whom and where we are at any given moment. However, certain individuals do assume roles as mentors based on their experience and knowledge within specific contexts, though no one person is considered an "expert" in the western meaning of the word. Thus, teaching and learning are always developmental, holistic, context-based, dynamic, and relational.

Our psychology training model is also conducted within a context of *interrelatedness*, better known as *Mitakuye Oyasin* in the Lakota language and translated into English as *all my relations. All my relations* refers to an Indigenous understanding of the self as related to one's family, clan(s), community(ies), nation(s), the natural world (e.g., earth, plants, animals, insects), and the spiritual world (e.g., Creator or Great Spirit, ancestors, spirit helpers) at once. *All my relations* invite interns to introduce and understand themselves from the context of their interrelatedness. It enables each of us to understand where all of us are coming from when we share our diverse knowledge as we learn throughout the training year.

To set the tone for the training year, for each week, and for many meetings, introductions and discussion are done in a traditional talking circle format. This involves one person speaking at a time, with protocols of non-interruption and respectful listening. Following Indigenous teachings, we share in a clockwise manner. From the beginning, this sets the foundation for good relationships and respect for diversity among interns, training staff, and others.

Supervisors' roles as mentors involve training with use of Indigenous pedagogical practices such as experiential activities, storytelling, and talking circles. Experiential learning involves applying material through hands-on engagement (e.g., practicing therapy skills and techniques using role-play, participating in community events or activities). Storytelling involves teaching through personal or traditional stories, which resonate and connect with interns through contextualizing didactic content and training in clinical services (e.g., supervisors often share stories from personal experiences and direct work experience). Traditional stories are also incorporated as appropriate, and interns are invited to share their personal and culturally relevant stories.

Talking circles offer opportunities for interns and supervisors to share what we have learned, honoring the diverse knowledge and understanding that each person brings. Each person thus assumes the role of teacher and student, enriching the learning environment and further strengthening good relationships. Experiential activities, stories, and talking circles strengthen interns' relationships with didactic training. Within supervision then, we are able to promote holistic integration of content and deep personal reflection that enhances learning and training.

Finally, intern feedback is invited and encouraged throughout the year and carefully considered, reflected on, and integrated through supervisor and program evaluations, so that supervisors and training staff may best serve the needs of the interns. Through intern feedback, consultation with other trainees, staff, and mentors, reading relevant literature, and personal reflection, supervisors continually strive to grow in providing adequate training. Learning is living and living is learning, and the Indigenous

values within being an effective supervisor and intern require engagement in ongoing personal and professional development throughout life.

Cultural Competency Guidelines for the Provision of Clinical Mental Health Services to American Indians in the State of Minnesota
(Drafted by the American Indian Mental Health Advisory Council)

While there are many similarities in the provision of mental health services across treatment populations, there are essential and unique components that must be considered when providing mental health services for American Indian clients. While American Indians are also unique individuals, there are consistent similarities across this cultural group that are unique to Indian people, and this knowledge is essential for the provision of efficacious mental health treatment for Indian people.

Of great importance in the formation of mental health practice guidelines in working with American Indians is that such guidelines must be dynamic. As individuals grow in their understanding of cultural identification, and as mental health services improve their standards of care, so must cultural competency standards accommodate improvements in treatment practices.

Similarly, it is not acceptable for an individual practitioner to declare himself "culturally competent" whether after attending one seminar, or a lifetime of working with clients from diverse populations. Rather, cultural competency is a developmental process for which a mental health practitioner strives, and always improves. Even if a practitioner is of the same race as his/her client, he/she may be of a different gender, socio-economic status, physical or mental ability, sexual preference, or religious background. These demographic variables may outweigh or modify race for particular clients, and thereby confound a clinician's understanding of how race affects mental health services for a particular cultural group. Also, clients of particular groups may or may not identify with their racial group; a variable that the "culturally enthusiastic" clinician may not be aware. Therefore, knowledge of a particular cultural group's beliefs, norms, and practices may not be adequate knowledge for "culturally competent" clinical care.

As part of the developmental pursuit of culturally competent mental health services for American Indians the following recommendations are presented as necessary but not sufficient guidelines for a mental health practitioner to follow:

Form a Connection with the Community

- *It is important to know how people are related in Indian communities, what family histories are, and who is considered a leader in the community.*
- *Visit local schools, community centers, and elder complexes, and volunteer when possible at these agencies*
- *Attend ceremonies if invited or appropriate*

Be Aware of Differences in Boundaries

- *Indian people may ask a clinician to attend a family event, visit their home, or accompany them to a religious event. It may be considered very disrespectful or alienating to refuse these gestures.*
- *An Indian client may ask personal information of a clinician before proceeding with the mental health session. Such a personal exchange is often seen as polite and caring among Indian people and should not be automatically dismissed by the clinician as unprofessional or trivial.*

Be Aware of Differences in Time
American Indians often do not feel the same sense of urgency in arriving at meetings or events at their scheduled time as Caucasian people do. Many Indian people will not arrive at a mental health appointment on time, or sometimes not at all, if they have something, they believe is more important to do. Events that may be considered

more important than mental health appointments often include family crises, ceremonies, deaths, or friends in need.

Understand definitions of family
In many Indian communities, family may be considered more than blood relatives; family may also be considered people who have been informally adopted, or simply raised by another person.

Awareness of Gift-Giving Practices
American Indian clients may give their mental health provider tobacco when asking for healing, or some other gift. Again, the clinician must use his/her judgment, and whenever possible, try not to dismiss the Indian client's gesture or intent in their gift giving.

Communication Styles among American Indians

- *Nonverbal Messages*
  Often Indian people communicate a great deal through nonverbal gestures, such as using downcast eyes or ignoring an individual when they are unhappy with or disagree with a person. Also, handshakes are generally done very gently and from the end of the fingers, instead of heartily and with the whole hand. Again, a gentle handshake is seen as respectful, and not a sign of weakness.
- *Humor*
  Indian people may say truths or difficult messages through humor and might cover great pain with smiles or jokes. It is important to listen closely to humor, as it may be seen as invasive to ask for too much clarification.
- *Indirect Communication*
  It is often considered unacceptable for an Indian person to criticize another. This is an important factor for a clinician to understand. Especially when it comes to Indians speaking out against or testifying against another person. Even if the individual has been exceedingly abusive, it may be considered disloyal or disrespectful to speak negatively about the other person. There is a common belief that people who have acted wrongly will pay for their acts in one way or another; although the method may not be the legal system.

Spirituality of American Indians

- *Given the abusive history that American Indians have suffered because of their spiritual practices, and the fact that it has only been legal for them to publicly display their religious practices since 1978 (American Indian Religious Freedom Act), many Indian people are very private and protective of their spiritual beliefs and practices. So, it may not be appropriate to ask probing questions about an Indian client's spiritual beliefs, or to assume that an Indian client has strong spiritual beliefs. Also, given the intensity with which Christianity has instilled itself into Indian culture, many American Indians strongly embrace Christianity and vehemently reject traditional American Indian spiritual beliefs and practices.*
- *Although there are great differences among American Indians regarding their spiritual practices, most Indian spirituality consists of a respect for life, a connectedness with nature, and a belief in a spiritual existence after the physical body has died. Also, most Indian religions promote the notion that one must be balanced between their physical, mental, emotional, and spiritual health; a concept that is important when providing mental health services for Indian people.*
- *It is critical that mental health professionals do not misdiagnose spiritual experiences as psychosis. If the professional is in doubt, he/she should consult with an American Indian spiritual leader. Also, a good rule of thumb is to question the message that the spirits are giving. If the message is for the client to harm him/herself or someone else, or if it causes the individual a great amount of distress and functional impairment, then it is more likely to be a case of psychological hallucinations than spiritual visitations. However, a spiritual leader should conduct the final assessment.*

Generational Mental Health Issues of American Indians

- *It is important for the mental health clinician to be familiar with accurate information regarding American Indian history over the last 400 years, and the trauma that Indian people have endured, in order to understand the present pervasiveness of mental health difficulties among Indian people. Specifically, given the disempowerment that Indian people have experienced from having their land taken, being forced on reservations, being beaten for speaking their native language and practicing their cultural ceremonies, and more recently having their children forcibly taken away by child protection, Indian people may tend to have very little hope in experiencing a just and full life. Also, alcoholism and abuse have been common responses to the generations of mistreatment Indians have experienced, and these responses have been passed through generations as acceptable and common methods to survive an "unjust" world.*
- *It is also important for clinicians to understand "healthy paranoia" or the concept that it may not be a delusion on the Indian client's part when he/she claims they were followed unnecessarily in a store, that they did not receive a job over a less-qualified Caucasian candidate, or that they were denied housing because of their race.*

Formality
While it is often common practice for a mental health professional to present himself or herself in formal dress, or using psychological vocabulary when interacting with clients, this may be counter-productive when working with American Indian clients. In fact, a large amount of education may be a detriment to the clinician's ability to heal and could add to the division between the clinician and the client. By contrast, when working with American Indian clients, a sense of casual professionalism on the part of the clinician is likely to increase the client's willingness to cooperate and participate in his/her treatment.

Humility and Patience
- *A clinician is more likely to gain the cooperation and trust of a client and his/her family if she/he is willing to approach the client in a humble stance, and not one of "absolute expertise." Quite often, the Indian client or his/her family will have insight into origins or solutions to problems that are not in mental health texts.*
- *Patience in particular is a very important attribute to adopt when working with Indian clients. Results or change are likely to occur at a rate much slower than that desired by the clinician, and "success" should be considered relative to the client's expectations, not the clinicians.*

Values
- *In order to create reasonable treatment plans for American Indian clients, it is essential to understand what concepts are of value and importance to the client. It may not be vital to the Indian client to attend college or have a "successful" career, while building and fostering a family may be very important to him/her. Given the collective tendency of American Indians, is likely, however, that family and support of the community will take precedence over individual achievement. However, individual achievement as a means to help the community may be highly regarded.*
- *If great important to the mental health clinician is an understanding of what health means to their Indian client. Does it mean functioning well enough to pay the bills or does it mean to realize dreams. It is imperative that the clinician does not impose the values of dominant society on their client or assume that the Indian client has grand material or academic aspirations.*

Cultural Identity Development
Fundamental to the provision of mental health services to American Indian clients is an assessment of his/her level of cultural identity. According to Sue and Sue (Counseling the Culturally Different, 1990), persons from diverse cultures often pass through a process of cultural identity, in which they 1) begin by identifying with the dominant culture and rejecting their own, 2) then begin to embrace their own culture and reject the dominant culture, 3) then see positive in the dominant culture, but continue to prefer persons from their own culture, and finally 4) see the strengths and weaknesses in both their own culture and the dominant culture, and accept them as they are. Given these different cognitive stances, a client can vary largely in how they view their current mental health, its etiology, and possible resolutions to their problems.

Psychological Testing

- *Standardized tests are based on data collected on specific demographic groups. Therefore, whenever possible, it is necessary for accuracy and reliability when conducting psychological tests on American Indian clients, to use tests with American Indian norms.*
- *When using the MMPI-2 with American Indians, it is important to note that this population often scores as psychotic when they have strong spiritual beliefs. Such an examinee may endorse items such as, "seeing things other people do not see," and are referring to spirits, not visual hallucinations. Also, American Indians tend to "spike" on scale 4 of the MMPI-2, or the paranoia scale. Again, caution is suggested when interpreting this scale, as many Indians do experience racism and injustice, which results in what the literature refers to as, "healthy paranoia."*
- *As with all psychological testing, rapport with the American Indian client is critical to obtaining valid results. However, it may require a longer process of interacting and gaining trust than is typical for Caucasian clients.*
- *Be cautious when conducting tests of speed, as an American Indian client may not feel the obligation to comply with such as request, given the common cultural ambivalence about strict dedication to time.*

While these recommendations are by no means exhaustive, they are the most commonly violated practices among American Indian mental health clients, and adherence to these few suggestions is likely to increase client cooperation and treatment success. When in doubt, the non-Indian clinician is highly encouraged to consult with an American Indian clinician. The following is a suggested reference list for the mental health professional in pursuit of cultural competency:

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CLINIC OVERVIEW

Clinic Description

The Counseling & Support Clinic of the Indian Health Board provides culturally competent mental and chemical health services to adults, children, and families. Most of the clients who use the clinic are of American Indian heritage, so emphasis is placed on providing services in a manner that best meets the needs of this community. C&S staff provides high quality services to clients in a courteous, professional manner while maintaining a comfortable, effective, and productive mechanism for rendering such care. Clients give informed consent for provided services and confidentiality is maintained within the limits prescribed by law.

Clinic Staff and Job Function

Kyle Hill, PhD, LP, Training Director, provides psychological services to adults, adolescents and children. He earned his PhD in Clinical Psychology from the University of North Dakota. He was also a student in the Indians into Psychology Doctoral Education (INPSYDE) Program and his research and training have been primarily in American Indian psychiatric help-seeking, suicide prevention, health equity and developmental psychopathology. Kyle recently obtained a Master of Public Health, and actively presents on public health and prevention as part of the didactic program. Kyle is an enrolled member of the Turtle Mountain Band of Ojibwe Reservation in North Dakota and a descendant of Sisseton-Wahpeton Oyate (Dakota) and Cheyenne River Sioux Tribe (Lakota).

Michael L. Harris, MA, LP, SEP, Director, is a licensed psychologist and has practiced at the Indian Health Board since 1995. He received his child psychology degree from the University of Minnesota in 1993 and completed his APA-Accredited Psychology Internship at Hennepin County Medical Center in 1995. Michael's areas of expertise include foster care & adoption, developmental & historical trauma, attachment problems, school problems, and Fetal Alcohol Spectrum Disorders (FASD). He is a Somatic Experiencing Practitioner® (SEP) and an active speaker/trainer on American Indian mental health topics and FASD. Michael has served as the Director of the Counseling & Support Clinic since 2002.

Amy Fish, PhD, LP, *Behavioral Health Consultant and Staff Psychologist,* provides behavioral health services in the primary care clinic with medical patients presenting to their primary care physicians. Additionally, she carries a caseload of children, adolescents, and adults for traditional psychotherapy and has created an interdisciplinary Eating Treatment Team with IHB's psychiatrist and registered dietician. Her areas of interest including self-injurious behaviors, suicidality, eating behaviors, and body image. She received her PhD in Counseling and School Psychology at The State University of New York at Buffalo with a specialty in eating disorders and multicultural issues. Amy is first generation descendant of the Onondaga Nation.

Luz Salinas, PsyD, LP, Staff Psychologist, attended Indian Health Board as a pre-doctoral intern and postdoctoral fellow from 2017-2019, taking a staff psychologist position after being licensed in the state of Minnesota in September 2019. Dr. Salinas provides clinical services to children, adolescents and adults, with emphasis on incorporating Indigenous ways of healing.

Thomas Murphy, PsyD, LP, Staff Psychologist, began at the Indian Health Board in 2012. He received his doctorate in Counseling Psychology from the University of St. Thomas and completed trainings in a variety of settings, including community mental health, CD treatment, corrections, college counseling, and private practice. He completed his doctoral psychology internship at Twin Cities Internship

Consortium (now titled Minneapolis Internship Consortium). Dr. Murphy's specialties are co-occurring mental health-chemical dependence issues, anxiety, and depression, with both adults and adolescents.

Andre Peri, PhD, LP, Integrated behavioral health manager, provides psychological services to adults, adolescents and children. He earned his PhD in Clinical Psychology from St. Louis University in St. Louis, MO, and has worked in diverse settings including at the VA, in private practice, a non-profit focusing on adults with developmental disabilities, an Employee Assistance Program, an IHS facility and at a tribal health department. Dr. Peri's areas of specialties are trauma, suicide and crisis intervention, anxiety and depression, and SMI.

Donald "Richard" Wright, LADC, CI, Indigenous Services Specialist, has worked at the Indian Health Board since February 2004. Richard attended the University of Minnesota majoring in General Studies with a minor in American Indian studies. He has been employed in the alcohol and drug field for 25 years. He previously has worked in community corrections and with the State Department of Corrections. More recently he worked for 11 years as a primary treatment counselor for American Indian adolescents in Minneapolis. Richard also is a national speaker on inhalant and solvent abuse, and non-beverage alcohols. Richard is married and has nine children, three of whom are adopted. He has raised countless foster children and is now a grandparent of thirteen. Richard is a graduate of the St. John's University, Archdiocese of St. Paul earning a Catechist Institute Degree bestowed on May 8, 2012. Richard also writes books and has had three publications, including a drug prevention curriculum and two articles in professional journals for addiction medicine. Richard is member of the Leech Lake Chippewa, Pillager band, born and raised at Onigum, Minnesota.

Robin Young, PsyD, LP, Chief Psychologist, provides psychological services to adults, adolescents and children. He received his doctorate in Clinical Psychology from Argosy University (Twin Cities) and completed his doctoral psychology internship and postdoctoral fellowship here at the Indian Health Board. Dr. Young's specialties are trauma and working with children and their caregivers.

Adriana Youssef, Ph.D., L.P. Staff Psychologist, received her doctorate in clinical psychology from the University of Minnesota in 2014, with a specialization in child psychology, clinical science, and developmental psychopathology. She completed an APA-accredited internship in Miami, FL Community Action and Human Services Department in 2013, providing services for Head Start and a domestic violence center. Currently at IHB, Dr. Youssef provides mental health services for children, adolescents, and adults. Along with the diagnosis and treatment of childhood problems, Dr. Youssef has expertise in the areas of infant and early childhood mental health, including maternal mental health in the prenatal/postpartum period. She is nationally certified in Trauma-Focused Cognitive Behavioral Therapy and has an interest in working with children and families impacted by trauma. She also has an interest in using culturally relevant skill-based parenting programs to promote children's resilience. Dr. Youssef is 4th generation Mexican American and a California native.

CLINIC SERVICES

Therapy	Individual	
	Family	parent/child siblings
	Couples	
	Group	
**Assessment*	Child	social/emotional attention difficulties learning FASD school observation
	Adult	psychological cognitive functioning
Social Work	Community resources Referrals Support groups Supportive counseling	
Special Services	Somatic Experiencing® (SE) Trauma Focused – Cognitive Behavioral Therapy (TF-CBT)	

Psychoeducational Services	Presentations, trainings and workshops to community members and professional groups regarding psychological issues, cultural competence, child development.
Transportation	Rides to and from appointments are available to clients through the Indian Health Board transportation department. Rides should be arranged through the Business Coordinator. Rides must be scheduled 24 hours in advance, and an adult must accompany children under 7.

Clinic Hours

The clinic hours are 9:00 a.m. to 5:00 p.m., Monday - Friday. Some transportation is available to clients from 9:00 a.m. to 5:00 p.m., with 24 hours notice, but transportation arrangements should always be conducted through the Business Coordinator.

***DENOTES CHALLENGE IN PRACTICE AREA DURING COVID-19 PANDEMIC.**

CLINICAL TRAINING

Training Meetings
All trainees are required to attend training meetings each week, scheduled as follows:

*Cultural Interview: (first) Wednesday, 12:00-2:00 p*m

Case Consultation: (all but first) Wednesdays, 1:00-2:00 pm
All C&S clinical staff and trainees attend this meeting. Cases are reviewed, as well as a variety of clinical topics. Staff usually eats their lunch during this meeting.

Trainee Seminar: (all but first) Wednesdays, 10:00-12:00 pm
C&S clinical staff and outside professionals facilitate this meeting so that trainees have an opportunity to meet with and learn from diverse staff who have a variety of clinical orientations and perspectives. Didactic topics such as ethics, play therapy, countertransference, attachment, and trauma will be covered.

Supervision
Supervision will address, but will not be limited to, assessment and diagnostic skills, cultural awareness, therapy skills and professional development. A supervision contract will be created early in the year, in order to identify strengths and needs and to make expectations clear. The primary supervisor will be responsible for co-signing trainee's documentation and supervising clinical and administrative aspects of the case. All Intake Summaries, Treatment Plans, chart notes, letters, written communications, reports, and Discharge Summaries must be co-signed by the supervisor.

Review of audiotape is a valuable aspect of the supervision process. Specific consent from the client and/or the client's guardian is required and consent forms are available. *Videotaping of clients and sessions is not permitted by trainees in this clinic, however, audio taping may be utilized in the training process.*

Emergency consultation with a licensed clinical staff member is always available and advised in crisis situations, particularly those that involve the assessment of suicide risk or danger to others. If all staff are in session when consultation is needed, it is acceptable to interrupt a staff provider's session. If possible, consultation should be sought from the supervisor.

***Assessment - Depending on COVID-19 pandemic status and virtual nature of client care, assessment may be limited throughout the training year.**
Trainees arrive with varying levels of assessment skill and experience. Because some amount of assessment is possible with each client, it is important to be proficient with all major categories of assessment and appropriate tests used at the Indian Health Board. Interns and Fellows are expected to administer, score, interpret and write reports on all relevant tests.

***Anishinabe Academy – Depending on COVID-19 pandemic status and school district public health policy, rotations at the schools may be limited throughout the training year.**
Interns and Fellows will be providing services onsite at a local elementary magnet school, Anishinabe Academy, once weekly during the regular school sessions. A schedule will be provided, along with

relevant training, supervision, and planning for the classroom therapeutic support. Careful planning of any trainee vacation or days off should take the local school calendar into consideration in order to miss as few days as possible and to maximize the limited time available for onsite services.

Therapy
A range of presenting concerns are treated, such as depression, anxiety, Posttraumatic Stress Disorder, attention problems, Reactive Attachment Disorder, Fetal Alcohol Spectrum Disorders, physical and sexual abuse, neglect and substance abuse. Interns receive training in both long- (at least six months) and short-term therapy and are supervised in utilizing a range of theoretical approaches, including cognitive-behavioral, psychodynamic, and play therapy. Proficiency in crisis intervention and management is valued and relevant training is provided. Trainees learn agency-specific and cultural competence guidelines while being encouraged to develop their own style of interviewing, professional writing, and treatment within those guidelines. Interns and Fellows may lead or co-lead therapy groups.

Cultural Awareness
Culturally aware treatment for the American Indian community is a primary focus of training at IHB. Relatedly, multicultural sensitivity and competence frequently guide topics for discussion and clinical areas of education and services. Monthly, American Indian community members and professionals are invited to present cultural trainings to provide perspective and understanding from the community's point of view. Cultural opportunities are available and expected for trainees to observe and/or participate in, such as powwows, school-based events, and ceremonies.

INTERN SELECTION

Interns are selected from applicants through the APPIC (Association of Psychology Postdoctoral and Internship Centers) website. Preference is given to graduate students from APA-accredited doctoral programs in professional psychology and American Indian applicants are especially invited to apply.

Applications are screened by the Training Director and training staff with priority given to experience in a community mental health setting, knowledge concerning trauma, sensitivity to diversity and competence with psychological evaluation and report writing. Applications are ranked according to the written materials, including reference letters, and the estimation of fit with the training program, with the top-ranked applicants invited to interview, preferable in person, although also arranged by phone. Following interviews, initial rankings are revisited and submitted to APPIC.

As a member of APPIC, IHB agrees to abide by the APPIC policy that no person will solicit, accept or use any ranking-related information from any intern applicant.

PRACTICA AND ACADEMIC PREPARATION REQUIREMENTS

- Graduate coursework and practicum training in psychotherapy and psychological interventions with adults and children, including competence with cognitive and personality assessment and the creation of written evaluations. An integrated psychological evaluation for both an adult and a child are expected.
- Graduate coursework and practicum experience with psychopathology and diagnostic assessment.
- Strong oral and written communication skills, efficient time management skills, and comfort and competence in challenging situations, including crises.

- Verification from the graduate program Director of Training that all coursework, comprehensive examinations and other required benchmarks will be completed by the internship start date.

Per job description:

- Enrolled in a doctoral program at a regionally accredited school and pursuing a doctoral degree in an applied psychology field.
- Completion of all doctoral level coursework in applied psychology field.
- 600 hours previous experience and training in clinical assessment and psychotherapy of children, adolescents, and/or adults.

TRAINING PROGRAM

Interns of the IHB Doctoral Psychology Training Program will gain experience working with children, adolescents, adults and families in a community healthcare clinic. Interns will spend approximately 75% of their time in outpatient psychotherapy and training activities, and 25% in outpatient assessment and related training and supervision activities.

On a weekly basis, interns spend at least two hours in direct clinical supervision of cases with their primary supervisor, one hour each in group supervision and case consultation with all clinical staff, and two hours of didactic and/or cultural proficiency training. As part of orientation, interns outline their interests, goals, and skills with the Training Director so that therapy and assessment cases that are commensurate with the intern's skills and interests may be assigned.

CLINICAL TRAINING EXPERIENCES AND GOALS

Interns learn agency-specific and cultural competence guidelines while being encouraged to develop their own style of professional writing, interviewing, and treatment within those guidelines. Interns develop basic competence in a variety of areas through direct clinical experience, didactic seminars, and team/group case consultations.

Clinical Experience

Interns provide treatment and assessment supervised by the Training Director and other IHB Licensed Psychologists. A range of presenting concerns are treated, such as depression, anxiety, Posttraumatic Stress Disorder, Attention-Deficit/Hyperactivity Disorder, Reactive Attachment Disorder, Fetal Alcohol Spectrum Disorders (FASD), physical and sexual abuse and neglect and substance abuse. Interns complete general psychological evaluations. They may lead or co-lead therapy groups and provide consultation to the Medical Clinic or other agencies.

Primary clinical experiences include outpatient therapy, consultation at Anishinabe Academy and psychological evaluation. Secondary clinical experiences may include group therapy, consultation with Medical Clinic staff and/or other staff within and outside IHB and provision of supervision.

Didactic Seminars

Didactic training is centered within Indigenous concepts of health and well-being, known as the *medicine wheel*. In addition, each didactic is selected according to the social-ecological model within the medicine wheel. Therefore, each week a didactic training experience is selected based upon the needs of the trainee, knowledge of clinic operations and clinical practice expectations, meeting training goals of internship and APA requirements. Altogether, didactics help ground the training experience from a

framework based on the four directions of the medicine wheel, and balanced health and well-being from Dakota and Anishinaabe concepts – *Physical, Mental, Emotional, and Spiritual;* while also careful to acknowledge social and developmental differences between these foundational elements. As a practical concern, the didactic program also recognizes social, cultural and political determinants of health as central to any training.

Interns, the Training Director, and interested agency professionals meet weekly as a group for approximately two hours of didactic seminar. Professionals from within the agency and the community are invited to lead seminars. Past seminar topics have included cultural interviews, climate change and mental health, decolonizing methodologies in treatment, public health program development and policy, Adverse childhood experiences and trauma in Indigenous communities, Indigenous ways of knowing (epistemologies), Suicide prevention and safety planning, child development, play therapy, Dialectical Behavior Therapy (DBT), attachment models, countertransference, Eye Movement Desensitization and Reprocessing (EMDR), psychiatric medication management, ethics and professional issues, supervision models and topics, and neuropsychological evaluation.

Interns provide a formal therapy case presentation twice a year and a formal assessment case presentation once a year.

Team/Department Case Consultations

Interns attend weekly case consultation and are exposed to a variety of viewpoints, intervention theories and recommendations at these meetings.

Training Goals

Goal #1: Competence in Theories and Methods of Psychological Assessment- Interns will develop competence in data collection for formal evaluation, skills in interviewing for diagnostic assessment and treatment, case formulation, appropriate use of tests and interpretation, skills in professional writing and feedback, as well as cultural sensitivity within diagnosing and test use/interpretation.

Objectives include: Interviewing and data collection for formal evaluation, Effective interview skills for diagnostic assessment for treatment, Accurate diagnosis and case formulation, Appropriate use of tests and interpretation, Professional writing and feedback, and Cultural competence.

Goal #2: Competence in Psychotherapy and Psychological Interventions-Interns will develop competence in effectively assessing patient risk management, appropriate case conceptualization and treatment planning, effective therapeutic interventions, Sensitivity to individual and cultural diversity, group therapy skills, and cultural competence within psychotherapy.

Objectives include: Patient risk management, appropriate case conceptualization and treatment planning, Effective therapeutic interventions, Sensitivity to individual and cultural diversity, Group therapy skills, Cultural competence.

Goal #3: Constructive Consultation, Supervision, and Program Evaluation - Interns will develop competence in effective consultation and communication, effective supervision and cultural competence within consultation, program evaluation and supervision.

Objectives include: Effective consultation and communication, Effective Supervision, Program evaluation, and Cultural competence.

Goal #4: Ethics and Professional Behavior - Interns will develop competence in developing and maintaining respectful relationships and cooperation with other disciplines, ethical behavior when interacting with clients, colleagues and other professionals, administrative competence and appropriate documentation, professional demeanor and identity, and cultural competence within ethical behavior.:

Objectives include: Respectful relationships and cooperation with other disciplines, Ethical behavior, Administrative competence and appropriate documentation, Professional demeanor and identity, and Cultural competence.

TRAINING PROGRAM OUTCOMES

Three times a year the intern's performance is reviewed and assessed, and progress is evaluated, during the first and second thirds of the year through the internship and once at the end of the year. The ratings are informed by direct observation, case consultation, supervision, audio recordings, and formal case and didactic seminar presentations. In addition, the interns will receive direct feedback throughout the year. At the half-way point and at the end of the year, interns are asked formally and informally to evaluate and provide recommendations to the Training Director regarding their internship experience. The areas of evaluation include: the quality of experience, supervision, training seminars, general satisfaction, progress in cultural proficiency, and the ability of the students and the internship to meet the trainee's major goals.

RESEARCH

Interns may spend a small percentage of their time on dissertation-related research, only of clinical responsibilities have been completed. This must be pre-approved by the Training Director. In addition, small, well-thought out pilot studies approved by the Internal Review Board may be conducted. Interns may have the opportunity to become involved in on-going outcome-based research.

SUPERVISION

IHB requires a minimum of three hours of weekly supervision, which includes two hours of individual supervision; one hour with the Training Director and one hour with a secondary supervisor who is a doctoral level licensed psychologist; and one additional hour of group supervision by attending case consultation with all C & S clinicians. Participation in the Anishinabe Academy rotation includes one hour of weekly group supervision as well. In addition, interns are provided supervision related to any groups they lead or co-lead with supervision meetings taking place once a week while the group is running. All supervision includes a discussion/exploration of clinical, ethical, theoretical, conceptual, and empirical aspects of clinical activities with clients. Each intern will have additional supervision for psychological evaluations. Finally, additional supervision with secondary supervisors is encouraged.

Interns may be offered an opportunity to work toward a competency in supervision. Interns may be invited to provide closely monitored supervision and/or co-supervision of the students due to the presence of assessment and therapy practica students within the IHB training program.

SALARY AND BENEFITS

The salary for full-time doctoral psychology interns is $26,520 for a 12-month period. Internship positions are protected by a labor agreement between IHB and SEIU Healthcare Minnesota; interns are required to pay nominal, monthly dues to SEIU. Full-time interns receive the following benefits, beginning on the first day of the month following a calendar month of employment:

• 14 days of PTO (paid time off)
• 7 paid holidays and 2 personal "floating" holidays
• Health insurance (currently, Blue Cross Blue Shield)
• Dental insurance (additional monthly premium, or free onsite basic dental services)
• Flexible spending account (pre-tax basis of employee contributions)

ADMINISTRATIVE ASSISTANCE

Business Coordinators are invaluable to the Counseling & Support clinic and, in their roles, create a safe and comfortable environment, facilitate client contact with providers, manage scheduling and facilitate documentation and billing.

INTERN PERFORMANCE EVALUATION/FEEDBACK/ADVISEMENT/RETENTION/MINIMAL REQUIREMENTS

A Supervision Contract (see Appendix A) is reviewed early in the year and is structured to communicate minimum responsibilities and expectations for both the supervisee, who is invited to add his/her reactions and input, and the supervisor. Feedback is implicit in this process and ongoing in supervision meetings. Written performance evaluations (see Competency Assessment Form, Appendix B) occur at the midpoint and end of the training year. Finally, an IHB-specific skills checklist (See Appendix C) is completed once or twice a year.
Per job description:

EVALUATION ACTIVITIES

- Participate in performance improvement activities, as needed.
- Proficiency testing conducted on an annual basis, to evaluate skills required for this position.
- Monthly productivity evaluation to assess the effectiveness of meeting clinic's measurable objectives

CHARTING AND DOCUMENTATION

Chart Notes
Chart notes are descriptions of what occurred during a session, meeting, and/or phone call. They are to be written in as objective language as possible and include descriptions of behavior or symptoms rather than theoretical analyses or hypotheses regarding the cause of these behavior or symptoms.

Chart notes must be completed by the end of the business day when the contact occurred and provided to the supervisor for review. **All notes and any outgoing correspondence must be co-signed by the supervisor.**

Treatment Plans and Intake Summaries

Completed Intake Summaries and Treatment Plans are required by the end of the third session or within 30 days of the diagnostic assessment (whichever is earlier). Treatment Plans must be updated every 90 days. See procedures in the Principles of Practice Manual for further guidance.

Billing for Services
Billing is done via Electronic Health Record.

Prior Authorizations
In some circumstances, prior authorizations are required before sessions will be paid by the client's insurance. Different insurances have different requirements, so trainees should consult with their supervisor, if they have questions about whether prior authorizations are required. See procedures in the Principles of Practice Manual for further guidance.

EMERGENCY PROCEDURES

Suicidal Client
In cases involving suicidal clients, the trainee must consult with a supervisor or other staff psychologist regarding the assessment of client's intent to harm self and level of risk. There are many clinical options to utilize in this situation, including contracting for safety, informing the client of on-call service and providing emergency numbers and crisis center information. These interventions should be determined on a case-by-case basis and will be discussed in training sessions and supervision. See procedures in the Principles of Practice Manual for further guidance.

In some cases, a client is significantly depressed but does not meet criteria (e.g., not imminently suicidal, no danger to self or others) for hospital admission. The Indian Health Board has a procedure for collaboration between the Counseling & Support Clinic and the Medical Clinic to quickly acquire antidepressant medication for these clients. However, a licensed psychologist must conduct this procedure, so again collaboration with a supervisor is essential.

When a client is depressed but is not in crisis, they may be encouraged to make an appointment to be seen in the Medical Clinic. The client should be directed to tell the appointment clerk that s/he is being seen for a medication evaluation regarding depression. The Medical Clinic will then allot them a longer appointment time than the standard ten-minute office visit.

Weather or Fire Emergencies
Emergency procedures to be followed, as well as warnings or announcements that will be heard can be found on a laminated information sheet and in the Employee Handbook. Please familiarize yourself with these procedures.

Because the fire drill is the most commonly encountered event, the procedure will be outlined here. The fire alarm is a high, piercing siren, which can be heard throughout the building. If you are in session at the time of a drill, explain to the client that there is no way to be certain that this is merely a drill and all precautions must be taken. The client should be guided to the nearest exit (either the stairwell near the elevator, or the stairwell through the back door in the kitchen), and across the street to the parking lot,

where staff and clients will wait for the all-clear signal. Child clients should be accompanied out of the building and supervised while outside. Clinic staff will check and close all treatment rooms before leaving the clinic. Feel free to assist in this process if you are able.

Waiting Room Safety & Supervision
When child clients are unaccompanied by an adult, it is necessary for them to be supervised during the time they are in the waiting room. This is to maintain both behavioral stability on the part of the client, and to prevent difficult interactions between the client and others who also may be waiting. Clinicians and trainees are responsible for their clients and must make sure the waiting room is supervised when unaccompanied children are present. Business Coordinators may be available to assist in this process, but ultimate responsibility lies with the clinician/trainee.

Mandated Reporting
See Principles of Practice Manual.

TRAINEE RESPONSIBILITIES

Training Agreements
Each of the schools which sends trainees to the Indian Health Board for training have formal letters of agreement which cover the expectations and limitations of the training site, the school, and the participating students. Please note that the Indian Health Board retains full responsibility for the care of clients, and has the authority to determine, via supervision, the course of care.

Trainee Responsibilities
Disclosure in Supervision
Because the Indian Health Board is responsible for the care of its clients, it is essential that trainees fully disclose information regarding their cases and sessions to supervisors. Trainees are not presumed to have unbiased judgment regarding what constitutes a significant event which may need to be discussed with the supervisor, so full disclosure is required. In the early stages of the internship or fellowship year, trainees may be requested to tape their sessions to facilitate this disclosure. Trainees also are responsible for reporting any mistakes they have made, suicidal clients, conflicts or impasses in the therapeutic relationship, accusations of unethical behavior, and any personal concerns that may impair therapeutic effectiveness. *While treatment decisions are made collaboratively between the supervisor and the trainee, the supervisor has the authority to determine the course of treatment and any interventions used.*

Notifying Clients of Trainee Status
Each client seen by a trainee (or guardian of a minor client) must be informed of his/her status as a trainee during the first appointment, and informed that s/he is working under supervision.

Professional and Ethical Behavior
Each trainee working under the supervision of a licensed psychologist is bound by the same rules, regulations, and codes that supervising psychologists must follow. Trainees are expected to follow all relevant professional and ethical codes of behavior and request consultation as needed.

Health Insurance Portability and Accountability Act (HIPAA)

Each trainee will receive training in confidentiality and HIPAA regulations.

Corporate Compliance
Each trainee must specifically review the corporate compliance section of the IHB Employee Handbook and sign the corporate compliance agreement located therein.

Fraternization Policy
Because of the inherent power differential between a trainee and other employees at IHB, as well as the potential for conflict of interest and/or dual relationship, trainees may not socialize beyond a casual or occasional level with any C&S clinical team member and/or any IHB employee, supervisor, manager, director, or board member, regardless of the circumstance. Trainees are expected to consult in supervision if they have a question regarding this policy.

INDIAN HEALTH BOARD RESPONSIBILITIES

The Indian Health Board will provide trainee with:
- Sufficient supervision to meet the requirements of their training program and their client load
- Timely evaluations of performance, in the format and schedule required by the trainee's school
- Confidentiality, within the limits defined below.

Confidentiality
All trainees, like clients, have the right to confidentiality. This assures trainees that their performance and needs will remain private from the public and from other trainees. However, the IHB supervisors' function as a training team, and therefore a trainee should expect that supervisors will confer with one another regarding the planning of training experiences and the evaluation of trainee progress. Because the schools require periodic reports of trainee's progress, a release of information must be signed by the trainee to allow IHB to disclose these evaluations.

INTERN TERMINATION

Termination is very rare and would be the end result of a detailed disciplinary process, outlined below. As stated in IHB policy:

TERMINATIONS

Except as specified in the Labor Agreement with SEIU Healthcare Minnesota, employment with IHB is at will. As such, employment is not for any definite period and may be terminated at any time, for any reason, through voluntary resignation by the employee or by the Company initiating the termination of an employee.

***Voluntary Resignations**: Non-exempt employees who choose to resign from the Company shall inform their supervisor in writing at least two weeks before the effective termination date. Exempt employees are expected to provide four weeks notice of their resignation. Supervisors must contact Human Resources immediately upon being notified of an employee resignation.*

Employees who resign and fail to provide the required notice as defined above will not receive payment for any accrued but unused PTO when they leave the Company.

Any employee who fails to work as scheduled for 3 consecutive workdays or who fails to return from approved absences without notification to management will be considered to have voluntarily resigned from the Company.

***IHB Property**: Employees must return all outstanding property belonging to IHB (such as keys, computer equipment, tools, books, etc.) to their supervisor before leaving the Company.*

***Involuntary Termination**: Refer to the Rules of Conduct section of this handbook for information on involuntary termination of employment.*

Employees who are terminated from IHB for cause, such as a policy violation, will not receive payment for any accrued but unused PTO when they leave the Company. Examples of infractions that warrant immediate discharge include, but are not limited to:

- *Assault against any person while in the service of IHB or on IHB property or premises.*
- *Bringing firearms or other weapons of any kind onto IHB property or premises, excepting pepper spray and mace.*
- *Engaging in physical violence or threats of physical violence of any type.*
- *The following violations of IHB's Drug-Free Workplace Policy:*
    - *Bringing and/or storing alcohol or illegal drugs or drug paraphernalia on IHB premises or property, IHB vehicles or any vehicle used for IHB business;*
    - *Using, consuming, transporting, distributing or attempting to distribute, manufacturing, selling or dispensing illegal drugs or alcohol;*
    - *Switching, tampering with or adulterating any specimen or sample collected under IHB's policy, or attempting to do so;*

- *Infraction of rules regarding patient abuse or conduct of a reckless nature that endangers patient safety or health.*
- *Dishonesty, including but not limited to, theft, embezzlement or falsification of IHB records.*
- *Improperly disclosing confidential IHB or patient information.*
- *Conviction of reckless driving of IHB equipment.*
- *Carrying unauthorized passengers while operating IHB vehicles.*
- *Gambling on IHB property or time.*
- *Absences for 3 consecutive working days without notifying management.*

***Exit Interviews**: IHB recognizes the importance of receiving comments and insight from our employees. Additionally, it is important to communicate with exiting employees' information regarding the handling of their benefits packages. As such, exit interviews with Human Resources are encouraged for anyone who leaves the Company for any reason.*

Supervisors are responsible for initiating termination paperwork, notifying HR, and completing a termination checklist prior to the employee's departure.

DUE PROCESS:

Identification and Management of Trainee Problematic Behavior and Grievances
Trainees make significant developmental transitions during the training period. Part of the training process involves the identification of growth and/or problem areas of the trainee. Clinical supervisors often identify these and deal with them in supervision. However, problems may sometimes require more formalized intervention.

This document provides C&S trainees and staff with an overview of the identification and management of trainee problems and concerns, a listing of possible sanctions and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems. We encourage staff and trainees to discuss and resolve conflicts informally but, if this cannot occur, the following formal mechanisms allow for response to issues of concern.

DEFINITION OF PROBLEM
Lamb et al. describe a problem as a behavior, attitude, or other characteristic that, although causing concern, is not excessive or outside the domain of expected behaviors for professionals in training (Lamb, Presser, Pfost, Baum, Jackson, & Jarvis, 1987). Problems are typically amenable to management procedures, supervision, or education. The formal procedures outlined below may be utilized if management procedures, supervision, or education do not result in improvement of the problem.

DEFINITION OF PROBLEMATIC BEHAVIOR
Problematic Behavior is defined broadly as an interference in professional functioning which is reflected in one or more of the following ways:

- An inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
- An inability to acquire professional skills in order to reach an acceptable level of competency; and/or
- An inability to control personal stress, strong emotional reactions, and/or psychological dysfunction which interfere with professional functioning.

It is a professional judgment when a trainee's behavior becomes problematic. Trainees may exhibit behaviors, attitudes or characteristics which, while of concern and requiring remediation, are not unexpected or excessive for professionals in training. Problematic behavior typically becomes identified when one or more of the following characteristics exist:

- The trainee does not acknowledge, understand, or address the problem when it is identified.
- The problem is not merely a reflection of a skill deficit that can be rectified by academic or didactic training.
- The quality of services delivered by the trainee is clearly negatively affected.
- The problem is not restricted only to one area of professional functioning.
- A disproportionate amount of attention by training staff is required.
- The trainee's behavior does not change as a function of feedback, remediation efforts, and/or time.

GUIDELINES FOR DUE PROCESS

Doctoral psychology interns occupy a unique position at Indian Health Board of Minneapolis, Inc. They are professional staff members and are thus subject to the policies and procedures applicable to professional staff. They are also graduate trainees at various institutions, and by completing a psychology internship are fulfilling an academic requirement of their home institution. All trainees, including psychology interns, may have multiple supervisors and reporting lines. It is therefore necessary to define a due process procedure that takes into account the company's personnel policies, the multiplicity of lines of authority over trainees, the duality of their status, and published professional standards. The following procedures clarify how Progressive Discipline shall be applied to trainees.

General due process guidelines include:

- Presenting to trainees, in writing, the program's expectations in regard to professional functioning at the outset of training,
- Stipulating the procedures for evaluation, including when, how, and by whom evaluations will be conducted,
- Using input from multiple professional sources when making decisions or recommendations regarding the trainee's performance,
- Articulating the various procedures and actions involved in making decisions regarding problems,
- Communicating early and often with graduate programs about any suspected difficulties with trainees,
- Instituting, with the input and knowledge of the trainee's graduate program, a remediation plan for identified problems, including a time frame for expected remediation and consequences of not rectifying the problems,
- Providing the trainee with a written statement of procedural policy describing how the trainee may appeal the program's actions or decisions,

- Ensuring that trainees have a reasonable amount of time to respond to any action(s) taken by the program,
- Documenting, in writing and to all relevant parties (e.g. the trainee's academic advisor or training coordinator, supervisors, etc.) the action(s) taken by the program and the rationale for those actions, and
- Ensuring that trainees receive adequate supervisory support for clinical work.

PROCEDURES TO RESPOND TO PROBLEMATIC BEHAVIOR

Basic Procedures

If a trainee receives an unacceptable rating from any of the evaluation sources in any of the major categories of evaluation, or if a staff member or another trainee has concerns about a trainee's behavior (ethical or legal violations, professional incompetence) the following procedures will be initiated:

1. In some cases, it may be appropriate to speak directly to the trainee about the concerns, and in other cases a consultation with the Training Director (TD) will be warranted. This decision is made at the discretion of the staff or trainee who has concerns.
2. Once the TD has been informed of the specific concerns, they will determine if and how to proceed.
3. If the staff member who brings the concern to the TD is not the trainee's supervisor, the TD will discuss the concern with the supervisor(s).
4. If the TD and supervisor(s) determine that the alleged behavior in the complaint, if proven, would constitute a serious violation, the TD will inform the staff member who initially brought the complaint.
5. The TD will meet with the training committee to discuss the concern.
6. The TD will meet with the Director to discuss the concerns and possible courses of action to be taken to address them.
7. The TD, supervisor(s), and Director may meet to discuss possible course of actions (as listed below).

Notification Procedures to Address Problematic Behavior or Inadequate Performance

Meaningful ways to address problematic behavior, once identified, are important. In implementing remediation or sanctions, the training staff must be mindful and balance the needs of the trainee with problematic behavior, the clients involved, members of the trainee's training group, the training staff, other clinic personnel, and the agency community. All evaluative documentation will be maintained in the trainee's file. The trainee's academic program will be notified of Verbal Notice at the discretion of the TD (in consultation with the Director) and of Written Notice(s) when they occur.

1. Verbal Notice to the trainee emphasizes the need to discontinue the inappropriate behavior under discussion.
2. Written Notice to the trainee formally acknowledges that:

a) the TD is aware of and concerned with the behavior,
b) the concern has been brought to the attention of the trainee,
c) the TD will work with the trainee to rectify the problem or skill deficits; and,
d) the behaviors of concern are not significant enough to warrant more serious action.

3. Second Written Notice to the trainee will identify possible sanction(s) and describe the remediation plan. This letter will contain:

a) a description of the trainee's unsatisfactory performance;

b) actions needed by the trainee to correct the unsatisfactory behavior;
c) the timeline for correcting the problem.
d) what sanction(s) may be implemented if the problem is not corrected; and,
e) notification that the trainee has the right to request an appeal of this action (see Appeal Procedures).

If at any time a trainee disagrees with the aforementioned notices, the trainee can appeal (see Appeal Procedures).

Remediation and Sanctions
The implementation of a remediation plan with possible sanctions should occur only after careful deliberation and thoughtful consideration of the TD, relevant members of the training staff and the Director. The remediation and sanctions listed below may not necessarily occur in that order. The severity of the problematic behavior plays a role in the level of remediation or sanction.

1. Schedule Modification is a time-limited, remediation-oriented closely supervised period of training designed to support the trainee's achievement of full functioning. Modifying a trainee's schedule is an accommodation made to assist the trainee in responding to personal reactions to environmental stress, with the full expectation that the trainee will complete the traineeship. This period will include more closely scrutinized supervision conducted by the regular supervisor in consultation with the TD. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:
a) increasing the amount of supervision, either with the same or additional supervisors;
b) change in the format, emphasis, and/or focus of supervision;
c) recommending personal therapy (a list of community practitioners and other resources are available);
d) reducing the trainee's clinical or other workload; and,
e) requiring specific academic coursework.

The length of a schedule modification period will be determined by the TD, supervisor(s) and the Director. The termination of the schedule modification period will be determined, after discussions with the trainee, by the TD, supervisor(s) and the Director.

2. Probation is also a time-limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the trainee to complete the traineeship and to support the trainee's achievement of full functioning. Probation defines a relationship in which the TD systematically monitors for a specific length of time the degree to which the trainee addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The trainee is informed of the probation in a written statement that includes:
a) the specific behaviors associated with the unacceptable rating (on the evaluation form and/or from an evaluation source);
b) the remediation plan for rectifying the problem;
c) the timeframe for the probation during which the problem is expected to be ameliorated; and,
d) the procedures to ascertain whether or not the problem has been appropriately rectified.

If the TD determines that there has not been sufficient improvement in the trainee's behavior to remove the probation or modified schedule, then the TD will discuss with the supervisor(s) and the Director possible courses of action to be taken. The TD will communicate in writing to the trainee that the conditions for revoking the probation or modified schedule have not been met. This notice will include

a revised remediation plan, which may include continuation of the current remediation efforts for a specified time period or implementation of additional recommendations. Additionally, the TD will communicate that if the trainee's behavior does not change, the trainee will not successfully complete the training program.

3. Suspension of Direct Service Activities requires a determination that the welfare of the trainee's client(s) or the clinic community has been jeopardized. When this determination has been made, direct service activities will be suspended for a specified period as determined by the TD in consultation with the trainee's supervisor(s) and Director. At the end of the suspension period, the trainee's supervisor(s) in consultation with the TD, will assess the trainee's capacity for effective functioning and determine if and when direct service can be resumed.

4. Administrative Leave involves the temporary withdrawal of all responsibilities and privileges at the Indian Health Board (IHB). If the probation period, suspension of direct service activities, or administrative leave interferes with the successful completion of the training hours needed for completion of the traineeship, this will be noted in the trainee's file and the trainee's academic program will be informed. The TD will inform the trainee of the effects the administrative leave will have on the trainee's stipend and accrual of benefits, including the possibility of no pay and no accrual of benefits.

5a. Dismissal from the Training Program involves the permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the problem behavior or concerns and the trainee seems unable or unwilling to alter her/his behavior, the TD will discuss with the Director the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a client is a major factor, or the trainee is unable to complete the training program due to physical, mental or emotional illness. The Director will make the final decision about dismissal.

5b. Immediate Dismissal involves the immediate permanent withdrawal of all agency responsibilities and privileges. Immediate dismissal would be invoked but is not limited to cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a client is a major factor, or the trainee is unable to complete the training program due to physical, mental or emotional illness. In addition, in the event a trainee compromises the welfare of a client(s) or the clinic community by an action(s) which generates grave concern from the TD or the supervisor(s), the Director may immediately dismiss the trainee from IHB. This dismissal may bypass steps identified in notification procedures and remediation and sanctions alternatives. When a trainee has been dismissed, the TD will communicate to the trainee's academic department that the trainee has not successfully completed the training program.

If at any time a trainee disagrees with the aforementioned sanctions, the trainee can implement Appeal Procedures.

Appeal Procedures

In the event that a trainee does not agree with the aforementioned notification, remediation or sanction, or with the handling of a grievance, the following appeal procedures should be followed:

1. The trainee should file a formal appeal in writing with all supporting documents, with the Director. The trainee must submit this appeal within five workdays from their notification of any of the above

(notification, remediation or sanction, or handling of a grievance).
2. Within three workdays of receipt of a formal written appeal from a trainee, the Director will consult with members of management and decide whether to implement a Review Panel or respond to the appeal without a Panel being convened.
3. In the event that a trainee is filing a formal, written appeal to disagree with a decision that has already been made by the Review Panel and supported by the Director, then that appeal is reviewed by the Director in consultation with the IHB Management Team. The Director will determine if a new Review Panel should be formed to reexamine the case, or if the decision of the original Review Panel is upheld.

TRAINEE GRIEVANCE PROCEDURES

Because trainees are part of the Indian Health Board's Internship Training Program as well as employees of the Indian Health Board of Minneapolis and therefore members of the SEIU Local #113 bargaining unit, grievance procedures fall under three categories. Grievances that involve items negotiated under the labor contract (for example pay scale, benefits, etc.) are subject to negotiated grievance procedures contained in the union contract. A union manual containing a copy of the labor agreement (and grievance procedures contained within) is provided to trainees during orientation. Trainees are also formally oriented by a union steward as to the labor contract and its provisions during the orientation period.

The second category of grievance involves all other Company policies (for example rules of conduct, safety in the workplace, etc.). The Indian Health Board's "Administrative Review – Grievance Handling" procedures, found in the Indian Health Board Employee Manual will govern such grievances. A copy of the employee manual is provided to trainees during their orientation period, and the procedure is reprinted here:

IHB has established an administrative review system (grievance procedure) to help solve problems as quickly, fairly, and informally as possible. This process should not be interpreted by any person as anything more than a method of solving problems before they reach damaging proportions.
All employees are eligible to bring forward for Administrative Review any perceived mishandling of a Company policy. The following Administrative Review process aligns with the Grievance and Arbitration Process outlined in the Bargaining Unit Agreement. Grievance filing and handling should be done with minimal disruption to work and serving patients.

Step 1
Employees should first discuss their policy concern with their immediate supervisor on an informal basis, attempting an early solution. The employee may or may not have a Union Steward present at this meeting.

Step 2
If Step 1 doesn't bring resolution, employees must provide a written, signed grievance to Human Resources within fifteen days of the occurrence. Within ten days of receiving the grievance, IHB and the Union are to meet to resolve the issue. Within ten days of the meeting, IHB shall respond in writing regarding its decision.

Step 3
If Step 2 doesn't bring resolution, IHB or the Union may refer the matter to Arbitration by submitting a written response within fourteen days of receiving Step 2's written decision.

The third category of grievance would be those items directly related to the training program itself and the trainees' experiences within the program. In general, trainees are expected to attempt to resolve

problems informally through discussion with the person involved. For purposes of trainee grievance procedures, the term "supervisor" refers to individuals having administrative authority over the policies, procedures, or person who is the object of the complaint with respect to the training program. The TD will act as supervisor with regard to all such grievances brought by trainees, except (1) those that involve complaints against the TD, in which case the Counseling & Support Director will hear the grievance, and (2) those that involve complaints against the Counseling & Support Director, in which case the Human Resources Manager and/or Chief Executive Officer of the Indian Health Board will hear the grievance.

The trainee should give the supervisor a written description, in as behavioral terms as possible, of the nature of the problem and the attempts that have been made to resolve it.

Step 1
Within three working days, the supervisor will provide written notification to the person(s) who is (are) the object(s) of the complaint. Such notification will include a copy of the trainee's written grievance. The supervisor will attempt an informal resolution with the person(s) involved.

Step 2
If Step 1 does not bring resolution, the C&S Director (unless the object of the complaint, in which case the CEO will act) will convene a Grievance Committee composed of him/herself, a licensed psychologist not part of the grievance at IHB, and a physician at IHB. This committee will meet and respond in writing to all relevant parties regarding the grievance and any remedies that must be made, if any. Remedies must be specific, measurable/observable, actionable, and time bound. The Grievance Committee will review progress on the remedies at the time the remedies are specified to be in place. If the grievance has not been adequately remedied, the committee may extend the deadline, add or modify remedies, or make other recommendations as to course of action. If the Grievance Committee finds no cause for remedy or action (at either stage of this step), then written notification will be made to all relevant parties as to the disposition of the grievance. In this case, the trainee may pursue an appeal (Step 3).

Step 3
If the trainee does not feel that the grievance has been adequately or appropriately addressed, s/he may appeal the Grievance Committee's decision within five working days from receiving written notification. If additional information or understanding of the grievance arises, the trainee may appeal to the Grievance Committee, which will meet and reconsider the new information and notify all relevant parties of the results of the appeal within five working days.

Step 4
If the trainee disagrees with the Grievance Committee and no new information is available, or if the trainee disagrees with the Grievance Committee's appeal results, s/he may request an appeal to IHB's Human Resources Manager or CEO within five working days. That person will convene an Appeals Committee (composed of the CEO or designate, IHB's Medical Director, and one additional Licensed Independent Provider at IHB) to review grievance information, remedies/actions, and interview relevant parties. The Appeals Committee will make every effort to address the grievance within two weeks. The Appeals Committee may allow the decision of the Grievance Committee to stand or may order new/modified remedies. The decision of the Appeals Committee will be final.

C &S NEW CLIENT PROCEDURES

Before initial appointment

- ❑ Review registration form, case and findings with supervisor
- ❑ Score and interpret the BASC-2, PHQ, etc. (as applicable)
- ❑ If client does not show for the initial appointment, consult with supervisor as to how to proceed

At initial appointment

- ❑ Provide credentials; trainee status and supervisor's name
- ❑ Review confidentiality and limits to confidentiality

  __Because privacy is so important, we are bound to keep our records and what we say confidential, or private. We are not able to say anything to anybody about what you tell me, what you are doing here, or even that you are coming here—without your (or your guardian's) written permission. This usually helps people talk about hard things or big feelings—because it's private. It's important to know, though, that an even bigger rule is about safety, and when someone we see as a client is in some dangerous situations, we are required by law to tell someone so that you will stay safe. The times that the law says we must break confidentiality include the following:

  __Abuse and neglect of any children or "vulnerable adults"

  __Imminent threat to self or other

  __Some court orders or subpoenas

  __Insanity defense

  __Pregnant mothers using alcohol, cannabis, PCP, cocaine, heroin, amphetamines, or methamphetamines
- ❑ Request consent to tape

  __We regularly ask new clients for permission to audiotape some appointments so that our supervisors can review how we are doing as a therapist. It helps the process because they get to actually hear what is happening with a client and can give advice based on their experience. It's good in case I miss something, so my supervisor can help me to better help you. We always ask for your permission to record, and if you don't give permission, we won't tape anything. If you do give permission, please sign this form….
- ❑ Diagnostic intake interview (CPT Code 90791)
- ❑ Feedback on any assessment completed at clinic intake and summary and recommendations
- ❑ Client schedules next appointment with Business Coordinator

Basic child assessment protocol

Please see separate testing recommendations form. ****

- ❑ Intellectual measure:

  __Wechsler Intelligence Scale for Children-Fourth Edition (WISC-4) - ages 6-0 to 16-11

  __Wechsler Primary & Preschool Scales of Intelligence-3 (WPPSI-3) - ages 3-0 to 6-11

- ❑ Executive functioning measure:
  - __* Porteus Mazes - ages 3 to adult
  - __Wisconsin Card Sorting Test (WCST) - 6-0 to adult
- ❑ Visual-motor measure:
  - __* Test of Visual-Motor Integration (VMI), Supplementary (Visual/Motor) - ages 3-0 to 17-11
  - __Bender-Gestalt – all ages
- ❑ Social-emotional measures:
  - __Rorschach Inkblots (Rorschach) - ages 5 to adult
  - __* Roberts Apperception Test for Children (RATC-2) - ages 6 to 15
  - __Projective Drawings: __House-Tree-Person (HTP) __Kinetic Family Drawings (KFD) - all ages
  - __* Children's Depression Inventory (CDI) - ages 7 to 17
  - __* Revised Children's Manifest Anxiety Scale (RCMAS) - ages 6 to 17
- ❑ Other available tests:
  - __Adaptive Behavior Assessment System (ABAS-II) - ages infant to adult
  - __Parenting Stress Index (PSI) – adult caregiver
  - __Conners' Continuous Performance Test (CPT 3.0) - ages 4 to adult
  - __Clinical Evaluation of Language Fundamentals (CELF-4) - ages 6-0 to adult
  - __Wechsler Individual Achievement Test-II (WIAT-II) – ages 4-0 to adult

<u>Following each assessment appointment</u>:

- ❑ Score testing immediately following each testing session; do not schedule appointments immediately following testing
- ❑ Complete the chart note: include the date, duration of assessment (generally, we are allowed to bill for some of the prep time for some insurance companies) and tests administered; record unusual or noteworthy verbalizations and observations and the plan (e.g., "Continue assessment to complete cognitive testing in one week. Report to follow.") Sign and return to supervisor for review.
- ❑ Ask questions during supervision and keep supervisor informed of new developments.
- ❑ When assessment is complete, review data with supervisor before beginning written report and to prepare feedback.
- ❑ Schedule a feedback appointment

Subsequent appointments:

- ❑ Chart entry must be completed before the end of business day
- ❑ Chart must be submitted to supervisor for review after each appointment (more frequently if additional contacts are made)
- ❑ Intake Summary is due by third appointment or within 30 days of first appointment, whichever is first
- ❑ Treatment plan is due by third appointment

- ❑ Authorized services vary by third-party payors; clinicians MUST have services authorized before seeing a client; urgent or emergency services may occur in consultation with supervisor or C&S Director
- ❑ Discharge summary is required after 60 days of no appointments or within one week of a client's termination or graduation

HANDY TIPS AND GUIDELINES

Access Codes

Voice Mail

To access voice mail from the clinic

Press "VM" button. You will hear "Welcome to IP Office. For help at any time . . ." Press your three-digit extension, followed by the number sign (#), or simply press # if you are calling from your own extension. (There are several trainee phone extensions.) You will hear "Please enter password and number sign." Press the four-digit password and the number sign.

When absent from the office, please change your outgoing message to indicate your absence and to direct the caller to the C&S front desk or general assistance.

To access voice mail from home:

Dial 721-9800. You will hear "Thank you for calling the Indian Health Board . . . "Press *7. You will hear "Welcome to IP Office. For help at any time . . ." Press your three-digit extension, followed by the number sign. You will hear "Please enter password and pound sign." Follow the prompts.

Dress Code

Attire is to be professional and suited to a business or health care setting at all times. Shorts are not to be worn. Closed-toe shoes are suggested, and mandatory if the trainee will be spending any time in the medical or dental clinic, due to OSHA requirements. Nametag is to be worn at all times.

Keys & Fobs

Trainees will be assigned keys and a fob for their use while at the Indian Health Board; these will be for the trainee office, the bathroom, your personal hanging file, and the work room (which also opens the kitchen, the records/fax room, and the group room). These are to be returned to IHB at the end of the training year. If keys are lost or stolen, this must be reported to the Business Coordinator immediately, and there will be a $10 replacement fee assessed before issuing a new key.

Timecards

Trainees and staff are required to punch in and out each day that they work. These records are used to calculate the trainees' time spent on-site, as well as for IHB's tax purposes in calculating donated time. For paid Interns and Fellows, this also tracks your pay. You will be issued an electronic nametag/identification card by the Payroll Clerk.

Paid Time Off (PTO) (time off policy for a 2080-hour internship)

Scheduled days off should be discussed with the trainee's supervisor as far in advance as possible because of clinical care issues. The internship year is 52 weeks long. Workdays are 8 ½ hours long for salaried staff, in order to allow for lunch. In order to meet the 2080-hour requirement (per Minnesota Board of Psychology, APPIC and APA), interns should generally expect to take a total of two weeks or less of vacation time and five days or less of sick time. Holiday time is included as part of the 2080-hour requirement. Trainees that are out for longer than a total of three weeks (15 business days) for any reason may be in jeopardy of not meeting the 2080-hour internship requirement. The Training Director will address this type of situation on a case by case basis. Late starts or extensions of the internship are rarely granted.

Calling in Sick
If a trainee is unable to work on an assigned day due to illness, it is necessary to call the Training Director and the Business Coordinator. While voicemail messages are appreciated, it is essential that the trainee reach one person directly to assure that the information has been received, and that clients' appointments can be canceled as needed. COVID-19 pandemic policies have also extended the amount of sick leave to 10 days of paid leave, provided that there is documentation from a provider that employee has been seen/tested during this time. Per clinic policy, IHB will also reach out and test the employee. Most importantly – if you feel sick do not come to work. The patient population that we encounter is high risk, and experiences health inequities that further this risk. Please note that, per policy, calling in is a Human Resources occurrence; repeated occurrences may result in disciplinary action (write-up).

Snow Days
In the event of severe winter weather, the Indian Health Board may be closed if it is determined that clients or staff would be unsafe traveling outdoors. Information regarding IHB closings will be broadcast on WCCO radio, and on the recorded greeting at the main IHB phone line (721-9800). If the Training Director is aware that you are scheduled to work on a day during which IHB will be closed, you will receive a call informing you of the closing early in the morning, likely between 6:30 and 7:00 a.m. If you do not wish to be called at home at this hour, please advise the Training Director of this. If you do wish to be contacted, please make sure that the Business Coordinator has your correct phone number.

SEIU Local 113
Paid Interns and Fellows are currently members of the Service Employees International Union (SEIU), Local 113, and are represented by SEIU 113. As such, there are certain monthly dues requirements and other union activities of which to be aware by contacting your local Union Steward.

Email and Internet Use Policy
Email accounts and computer/internet access will be created for each trainee during the orientation period. Email and internet policies will be reviewed, and each trainee will be asked to sign the policies, acknowledging that s/he will comply with them. Please be aware that, per IHB policy, managers may look at supervisees' emails, without formal reason/basis, and this process also may include review of websites visited.

Other Items
Most other information will be found elsewhere in this manual, the Principles of Practice Manual, the IHB Employee Handbook, or the SEIU 113 Labor Agreement contract.

STATEMENT OF NONDISCRIMINATION
IHB complies with all applicable equal employment opportunity laws and regulations. IHB provides equal opportunity employment for all qualified persons. All our employment practices, benefits and programs will be administered without regard to actual or perceived race, color, religion, sex, national origin or ancestry, age, disability, veteran status, sexual orientation, marital status, status with respect to receipt of public assistance or any other basis protected by federal, state or local law.
This commitment extends to all phases of employment including, but not limited to, recruitment, selection, placement, transfers, training and development, promotions, demotions, compensation, benefits, work force reductions, terminations, and all other conditions or privileges associated with employment, except as required under the provisions of Public Law 93-638 to implement an Indian Preference policy.

In establishing this policy, IHB recognizes the need to initiate and maintain affirmative personnel measures to ensure the achievement of equal employment opportunities in all aspects of our workplace settings, conditions and decisions. It shall be the responsibility of all employees to abide by and carry out the letter, spirit and intent of the IHB commitment to equal employment commitment and comply with the guidelines set forth in IHB's Affirmative Action plan.

EEO policy statements are posted on employee bulletin boards, describing these policies in specific detail.

Supervision Plan

Date of hire:
Date of implementation:
Review due date:

Purpose of supervision:_____

Number of supervision hours required:_____

Supervisee (Minnesota Rule 9505.0371, subpart 4, item C, 1):

Name:_____

Graduate program:_____

Professional degree/status:_____

Regulatory board (if applicable):_____

Supervisor (Minnesota Rule 9505.0371, subpart 4, item C, 2):
Name: Kyle Hill, Ph.D., L.P.

Experience: Ten years of direct service (three under my own license) including individual therapy, group therapy, school-based counseling, Psychoeducational and clinical assessment, crisis/risk assessment, diagnostic and psychological assessment. Competence in the areas of anxiety, trauma/stress disorders and mood disorders, personality disorders, anxiety disorders and work within American Indian/Indigenous communities. Supervisory experience includes work with trainees for 2 years and training director beginning in 2019.

Philosophy/Approach to supervision: Supervision is a mix of process and content. Most important is self-care, as well as an understanding of your cultural background and values/beliefs coming into the patient interactions. I want to hear you talk about the therapy – or anything that you want to discuss – and, most often, I want to be able to look at the chart at the same time, especially for new clients, to see if the documentation matches what is being said. So, please bring all registration and documentation for new clients. In my opinion, documentation is the only "evidence" that an event in the therapy relationship took place, whether it is a phone call or a Diagnostic Intake or a session. If it is not written, it did not occur. Documenting in a timely and complete manner is respecting the client and the process. If you are unavailable, for whatever reason, and the client needs something, your supervisor or colleague should be able to easily find the information that they need in the chart (EHR). I tend to be firm about documentation timelines, with consequences for a pattern of tardiness. My stance also reflects the requirements of third-party payors.

Because I read actively and, in the moment, I expect that whatever edits I make are returned to me with the next draft of the material. That way, I do not have to re-read the document. If you have made changes that were not included in my edits, please point them out to me, as I will pay close attention to the required changes but will not necessarily re-read the document.

Needs Assessment
Transcripts & Curriculum vitae.

Past knowledge and skills related to:

- Evaluation and treatment
- Ethics

- State and federal laws and rules
- Record keeping
- Methods for establishing an appropriate treatment relationship with clients
- Professional strengths as identified by supervisee and former supervisors/teachers
- Professional weaknesses or concerns about supervisee's practice as identified by supervisee and/or former supervisors/teachers
- Supervisee's greatest sources of professional concerns and anxiety
- Supervisee's greatest sources of professional pride and accomplishment
- Supervisee's specific learning needs
- Supervisee's favored learning style

Logistics (Minnesota Rule 9505.0371, subpart 4, item C, 3):
As agreed, we will meet Friday at 2:00pm, in my office, for one hour in duration. In the event that you are unable to attend a meeting, contact me, preferably in advance, to reschedule.

Supervisor availability and contact methods (Minnesota Rule 9505.0371, subpart 4, item C, 4):
Should you need to speak with me outside supervision, my cell phone number is 701.330.9462. In my absence, any other licensed staff at the clinic may be consulted.

Emergency procedures (Minnesota Rule 9505.0371, subpart 4, item C, 5):
Please read and follow agency guidelines regarding crises. I prefer that supervisees error on the side of caution and share everything about which they have concerns and/or questions.

Supervisor's rights:
- Information needed to provide appropriate clinical supervision
- An atmosphere free of verbal, physical or sexual harassment

Supervisor's responsibilities:
- Provide supervision that is appropriate to my supervisee's professional needs and that meets the requirements of professional ethics and state and federal rules and laws
- Schedule regular supervisory meetings and be available for emergencies
- Conduct a learning needs assessment and establish clear learning objectives, activities for mastery of learning objectives and criteria for mastery of learning objectives
- Teach practical clinical skills, including the characteristics and contents of good clinical records and help my supervisee integrate theoretical knowledge with clinical skills in order to develop professional competence
- Regularly assess my supervisee's progress, including identification of strengths, weaknesses and errors; provision of appropriate feedback; and, development of plans for improvement
- Help my supervisee identify when a patient may have special problems that require another professional's consultation
- Help my supervisee appropriately manage transference, countertransference and professional boundary issues as indicated
- Seek consultation with and input from other staff regarding supervisee's performance, including what is shared in supervision, with as much regard for privacy as possible, with the exceptions of requirements of policy or regulation
- Conduct formal performance evaluations as required. Honestly communicate performance evaluation results, including professional strengths, as well as any unresolved practice errors and ethical concerns, to those persons who require the results

Supervisee's rights:
- Have weekly supervisory sessions that will focus on my learning needs and my clients' treatment needs

- Understand and participate in the development of my learning objectives, activities to meet learning objectives, and standards for mastery of learning objectives
- Know my supervisor's professional qualifications (education, training, licensure, competencies, experience, treatment approach, biases)
- Have regularly scheduled performance evaluations, which are sent in a timely manner to the appropriate institute
- Not be discriminated against in the provision of supervisory services on the basis of my race, gender, ethnic origin, disability, creed or sexual orientation
- Not be harassed or exploited in other ways to meet my supervisor's personal needs or the needs of the agency

Supervisee's responsibilities:

- Practice ethically and protect clients from harm
- Work within the limits of competency, skill and training
- Actively participate in supervision to promote skill development
- Be honest and open, share deficits and report mistakes
- Provide supervisor with honest feedback about supervision and the supervisory process
- Understand the importance of clarity, objectivity and self-awareness as crucial for ethical practice
- Become the best professional possible
- Bring all of my clinical cases, including potential client records, to my clinical supervisor for honest and direct discussion and review
- Provide my clinical supervisor with access at any time to my patients' records for review
- Thoroughly present each of my clients' cases verbally and in writing, including all factors relevant to diagnosis and treatment such as: presenting problems; history of problems; significant childhood, family relationship, work and other life history; medical treatment; medications; past treatment; mental status observations; diagnoses; treatment plans; my record keeping; and, other professional issues, including transference and countertransference feelings
- Inform clients of exceptions to confidentiality, including that my clinical supervisor will be discussing my sessions and reviewing and signing all of my documentation
- Provide a contingency plan during absences from the office, whether planned or unplanned, covering voicemail, email and, most importantly, clinical care for clients
- Read, understand and adhere to this agency's security and privacy policies and procedures
- Follow state and federal rules and laws, as well as rules and professional ethics code requirements and to discuss ethical and legal questions or problems as they arise in each of my cases

Description of supervisee's service responsibilities (Minnesota Rule 9505.0371, subpart 4, item C, 6):

As your supervisor and a licensed psychologist, I am responsible for your practice under my license. The scope of your practice will involve conducting diagnostic and risk assessments, developing treatment plans, providing psychotherapy and documenting all activity.

- For training purposes, you first will shadow at least two diagnostic assessments performed by C&S providers. When you are familiar with the process, you will be shadowed by C&S providers in the provision of at least two diagnostic assessments.
- All of your diagnostic assessments will be reviewed and signed by me.
- Supervision will include an exploration of the use of self-regarding culturally mindful practices, to increase your awareness of how your own culture impacts the therapeutic process, case conceptualization, differential diagnosis and clinical summary.

    Racial or ethnic self-identification; experience of cultural bias as a stressor; immigration history and status; level of acculturation; time orientation; social orientation; verbal communication style; locus of control; spiritual beliefs; and, health beliefs, including culturally-specific healing practices, possibly a cultural genogram

- Progress notes and treatment plans will follow the same training curve; you will observe others', be observed and become independent with consultation and supervision.
- Provision of psychotherapy also will be monitored, through observation (when possible), audiotaping, and exploration in supervision, with the goal of skill mastery and ample time for exploration of your impressions and concerns, as well as those of the supervisor.
- Supervision meetings will be documented, with the possibility of both supervisee and supervisor signing each meeting note. A supervision file specific to you will be maintained and will include notes of recommendations for specific cases as well as targets for your professional skills and growth. You are responsible for maintaining your own supervision notes, and any related notes in client charts.
- Administrative issues and billing procedures are your responsibility and supervision will provide support in these areas.

Remember that the services you provide are billed under my professional license, which means that I am responsible for the care you provide. In order both to protect my license and for you to become an adequately prepared and professionally competent provider, we need to partner in the monitoring of client care and your personal and professional growth.

Description of the client population:
The majority of clients served at IHB are American Indians and immersion in the Native culture is an integral part of training. We define and expect that diversity encompasses all of the following and that respect will be offered regardless of: age, race, ethnicity, culture, immigration status, disability, educational level, religion, gender, sexual orientation, gender identity or expression and socioeconomic status.

You will see children and adults who reside in and around Minneapolis, Minnesota. The majority have insurance, although sliding fees are offered.

Treatment methods and modalities:
Individual therapy is the primary modality at C&S. The goals that you identify in supervision will guide our work together and consultation will be sought in areas where my expertise may not be sufficient to support your learning experience. My competence to train you is based in my own education, clinical experience, and ongoing training.

Evaluation procedures:
Date formal supervision evaluations will be conducted:_____

To whom evaluations will be sent:_____

Discipline and due process:
Please read and request any necessary clarification regarding the Due Process policy which incorporates agency-level guidelines as well as those specific to C&S.

Mutual agreement:
Your signature below indicates that you agree to practice ethically, professionally and legally while in supervision. Our signatures acknowledge that we both agree with the content of this plan and that any changes to it will be reflected in a revised and signed document.

Kyle Hill, PhD, LP Licensed Psychologist Supervisor	Date	Name Supervisee	Date

Appendix B

Indian Health Board of Minneapolis
Counseling & Support Clinic

Doctoral Psychology Intern/Post-doctoral Fellow
Competency Assessment Form

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Standards for Completion of Training
Comments and Signatures

Directions for use of computerized format: This form may be completed on computer and only the ratings being given to the intern or fellow need to be printed. Copy the document, rename it, and delete the ratings not being given before printing.

Indian Health Board of Minneapolis
Counseling & Support Clinic

Doctoral Psychology Intern/Post-Doctoral Fellow
Competency Assessment Form

This form is to be filled out at least two times per year, or more often in cases of remediation.

Trainee

Supervisor

Training Year

Date

Assessment methods for this evaluation

Direct Observation	Review of written work
Review of raw test data	Case Presentation
Audio recording	Personal Supervision
Collateral information	

Competency Ratings Definitions & Expectations for Training Completion

Please rate and circle the number denoting the intern's skill level using the scale below:	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

NA. Indicates not applicable or not assessed by this evaluator

Independent/Autonomous (Rating of 5): Indicates skill set necessary beyond licensure.

Postdoctoral Exit Level (Rating of 4): Typical skill set for end of the postdoctoral year and is ready for licensure.

Doctoral Psychology Internship Exit Level/Postdoctoral Entry Level (Rating of 3): Typical skill set for end of internship or during postdoctoral training. Requires supervision but displays highly developed professional skills and judgment. Generally achieved in 6-12 months of internship.

Intermediate Internship (Rating of 2): Typical skill set for practice during internship. Displays significant knowledge of role and can function professionally with regular supervision. By December 31st, no more than 25% of competencies (nineteen total) will be rated below a 2. By April 30th, no more than 15% of competencies (eleven total) will be rated below a 2.

Internship Entry Level (Rating of 1): Typical Practicum level skill set. Requires continuous supervision but accepts it. Expected to last no longer than the first 1-4 months of internship.

Unsatisfactory/Pre-Internship Level (Rating of 0): Displays significant problems beyond a lack of opportunity to learn skills. May have apparent lack of aptitude for the task or role or may be avoiding or resisting changing clinical behavior or expanding skill set. This includes unethical practice or repeated boundary violations. *The evaluator is to specify what specific areas need remediation in the comments section for any given objective and summarize a recommended course of action at the end of this assessment form.*

All higher-level ratings are presumed to contain the lower level competencies as well.

Training Goals: By the end of the training year, an Intern will be able to demonstrate skills at the Doctoral Psychology Internship Exit Level/Postdoctoral Entry Level or higher for all competencies. By the end of the training year, a Postdoctoral Fellow will be able to demonstrate skills at the Postdoctoral Exit level for all competencies.

Goal 1. Competence in Theories and Methods of Psychological Assessment

Objective 1.1. Interviewing and Data Collection for Formal Evaluation

1.1. an Interviews skillfully to collect relevant information.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.1. b Uses understanding of behavior and mental illness to shape interview questions.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.1.c. Shapes interview process to collect maximal range of data collection.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.1.d. Describes interview data effectively.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

Comments (<u>Two the three sentences required, and anything rated below the minimal level of achievement must be commented on</u>):

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Objective 1.2. Effective Interview skills for Diagnostic Assessment for Treatment

1.2.a. Readily establishes rapport.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.2.b. Efficiently gathers clinical information.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.2.c. Informs clients of status, data privacy and confidentiality concerns.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.2.d. Attends to relevant administrative details and paperwork.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.2.e. Appropriately attends to the client's needs through the assessment or evaluation process.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.2.f. Diagnoses entered into computer and discussed with other members of the treatment team as appropriate.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 1.3. Accurate Diagnosis and Case Formulation

1.3.a. Makes diagnoses based on the best available information.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.3.b. Formulates diagnostic, clinical and referral issues clearly.

5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.3.c. Able to use diagnostic instruments effectively to support diagnosis.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 1.4. Appropriate Use of Tests and Interpretation

1.4.a. Selects and uses psychometric instruments appropriate for task.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.4.b. Understands roles and limits of psychometric instruments.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)

2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.4.c. Administers tests accurately and according to standard protocols.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.4.d. Integrates implications of cultural variations in test results.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.4.e. Integrates test and interview data to form sound hypotheses and formulations.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.4.f. Makes effective recommendations to referral sources.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 1.5. Professional Writing and Feedback

1.5.a. Writes clearly, communicates effectively and organizes information efficiently.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.5.b. Uses appropriate grammar and effective rhetorical skills.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.5.c. Avoids jargon and communicates clinical information meaningfully to non-psychologists.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 1.6. Cultural Competence

1.6.a. Appropriately considers cultural factors in client presentation.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.6.b. Recognize misdiagnoses and historical implications of diagnoses in marginalized groups.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.6.c. Understands the value of utilizing empirically validated techniques and their use within certain populations.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.6.d. Interpret test results with cultural factors in mind and report these factors within the report.	
5	Independent/Autonomous (full performance level)

4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

1.6.e. Able to discuss results in a culturally appropriate manner.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Goal 2. Competence in Psychotherapy and Psychological Interventions

Objective 2.1. Patient risk management

2.1.a. Effectively evaluates, documents, and manages clinical risk, including suicidality, homicidality, abuse of others, child neglect, or other safety concerns.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.1.b. Manages privacy issues in risk situations.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)

3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.1.c. Develops plans for safety and collaborates with clients, family, and other providers and personnel including hospitals and law enforcement.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 2.2. Appropriate case conceptualization and treatment planning

2.2.a. Recognizes and structures treatment based on scientific, theoretical and practical principles of client care.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.2.b. Writes collaborative treatment plans reflecting a scientific and theoretical framework.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)

3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.2.c. Researches diagnoses and incorporates scientific knowledge into treatments.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.2.d. Individualizes treatment to accommodate individual and cultural differences.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.2.e. Designs coherent objectives of treatment.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.2.f. Documents outcomes.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 2.3. Effective therapeutic interventions

2.3.a. Uses appropriate and targeted clinical interventions.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.3.b. Uses empirically validated interventions where possible or can justify reasons to do otherwise.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.3.c. Implements interventions skillfully.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.3.d. Communicate empathy to clients.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.3.e. Manages expected caseload effectively.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 2.4. Sensitivity to individual and cultural diversity

2.4.a. Accepts and seeks knowledge and understanding of individual and group differences, including ethnicity, race, gender, religion, sexual orientation and other concerns.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.4.b. Responds with sensitivity and respect to differences.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.4.c. Empowers clients to find resources relevant to their own identity.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.4.d. Aware of impact of clinician's own diverse identities. Recognizes own limits and prejudices.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 2.5. Group therapy skills

2.5.a. Understands group theory.

5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.5.b. Manages group process effectively and intervenes when appropriate.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.5.c. Encourages participation of all while simultaneously fostering the development of group cohesion.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.5.d. Functions well in different types of group settings.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.5.e. When appropriate, prepares and effectively facilitates psycho-educational, experiential or skills-building in a group format.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)

1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

2.5.f. Demonstrates firm understanding of group theory and didactic materials presented.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 2.6. Cultural Competence

2.6.a. Understands importance of establishing rapport, historical trauma, effects of oppression on individuals and groups, effectiveness of different therapeutic styles and models and different worldviews.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Goal 3. Constructive Consultation and Supervision and Program Evaluation

Objective 3.1. Effective consultation and communication

3.1.a. Communicates concerns and recommendations clearly, both orally and in written form.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.1.b. Offers useful feedback in clinical team meetings, in consultation with outside agencies and the public.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.1.c. Conceptualizes effectiveness of programs and interventions and can communicate targets for change.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.1.d. Demonstrates awareness of ethical guidelines pertaining to consultation.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)

2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

Comments:_____
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Objective 3.2. Effective supervision

3.2.a. Within peer supervision and peer review, able to provide constructive feedback, supervisory suggestions, and supervisee skills and shortcomings.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.2.b. Demonstrates awareness of ethical guidelines pertaining to supervision.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.2.c. Able to articulate models and/or philosophies of supervision and relevant research.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)

0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 3.3. Theories and Methods of Program Evaluation

3.3.a. Developed expected skills in knowledge of evaluation of a program or an intervention (at the individual or group level).	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 3.4. Cultural Competence within Consultation, Supervision and Program Evaluation

3.4.a. Expresses knowledge and awareness of cultural diversity issues within peer supervision, consultation and in evaluation of a program or intervention.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)

3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

3.4.b. Demonstrates competence in providing feedback in report-writing through peer review, especially psychological testing and limitations based on cultural differences from norms.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Goal 4. Ethics and Professional Behavior

Objective 4.1. Respectful Relationships and Cooperation with Other Disciplines

4.1.a. Makes contributions to a team.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.1.b. Works effectively with others. Resolves differences in a way that promotes quality work and fosters working relationships.	
5	Independent/Autonomous (full performance level)

4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.1.c. Respectful relationships and cooperation with other disciplines. Able to work well with other professional disciplines.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 4.2. Ethical behavior

4.2.a. Familiar with ethics and relevant state law and consistently applies this to practice.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.2.b. Maintains appropriate professional boundaries.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)

2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.2.c. Seeks consultation regarding ethical dilemmas as they arise.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 4.3. Administrative competence and appropriate documentation

4.3.a. Able to prioritize and complete administrative tasks and paperwork in ways that meet agency standards and promote quality of service.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.3.b. Abides by principles of confidentiality and behaves in manner fully consistent with HIPAA guidelines.	
5	Independent/Autonomous (full performance level)

4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.3.c. Demonstrates time management skills in managing multiple expectations.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 4.4. Professional demeanor and identity

4.4.a. Sees self as a professional and is confident in this role.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.4.b. Able to convey a sense of confidence and professionalism to others.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)

2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

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Objective 4.5. Cultural Competence

4.5.a. Recognizes the tension between professional expectations and the conflicts that may arise in different cultural settings (worldviews, ways of perceiving mental health problems, appropriateness of gift-giving) and practices effective and appropriate means of addressing the tension.	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

4.5.b. Displays awareness of possible tension in the supervisory relationship related to differences between supervisor and supervisee (culture, gender, privilege/class, race and so on) and is available for a dialogue with the supervisor and others in order to find/create safe places to address any such tensions	
5	Independent/Autonomous (full performance level)
4	Postdoctoral Exit Level (no supervision needed)
3	Internship Exit Level/Postdoctoral Entry Level (little supervision needed)
2	Intermediate Internship (some supervision needed)
1	Internship Entry Level (close supervision needed)
0	Unsatisfactory/ Pre-Internship Level (remediation plan needed)

_____NA: Not applicable or not assessed by this evaluator

Comments:_____
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Competency rating tally:

December 31 By December 31st, no more than 25% of competencies (nineteen total) will be rated below a 2 for a doctoral psychology intern, or below a 3 for a post-doctoral fellow.

April 30 By April 30th, no more than 15% of competencies (eleven total) will be rated below a 2 for a doctoral psychology intern, or below a 3 for a post-doctoral fellow.

August 31 By end of internship year, no competencies will be rated below a 3 for a doctoral psychology intern, or below a 4 for a post-doctoral fellow.

Summary of trainee's main strengths and assets:

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Recommendations for continued development – areas in need of improvement that do not yet meet the threshold for formal remediation:

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This assessment has been reviewed and discussed with the doctoral psychology intern or post-doctoral fellow.

Supervisor _____ Date _____

Intern/Fellow _____ Date _____