**POST-DOCTORAL RESIDENCY PROGRAM**

The post-doctoral program in Clinical Psychology is sponsored by Aurora Community Mental Health Center (AuMHC), in Aurora, Colorado. AuMHC is a private, non-profit agency which has been serving the Aurora community since 1975. Last year we served over 19,000 clients ranging in age from infancy to over age 90. These services take place in outpatient clinics, schools, medical clinics, hospitals, residential facilities and nursing homes throughout our catchment area. The city of Aurora is among the most culturally and ethnically diverse cities in the United States. For further information about Aurora Mental Health, please visit our website: [www.aumhc.org](http://www.aumhc.org).

Post-doctoral residents have a primary placement for twelve months and two six-month minor rotations. The primary placement averages 20 hours per week and the minor rotations are 16 hours per week. The provision of weekly direct psychological services averages 15 to 20 hours. Residents receive at least two hours of weekly individual supervision from a licensed psychologist. They also participate in weekly interdisciplinary group supervision team meetings at each site, which include clinical and administrative group supervision, for a total of at least two hours of weekly group supervision. Residents will supervise a graduate practicum student and receive supervision of supervision. There are weekly didactic trainings that cover broad areas of professional development including the development of supervision skills, working with couples, specialized assessments (e.g., for early childhood and geriatric populations), preparing for the EPPP, career exploration, and leadership development. Additional training components include monthly case conferences with the Training Director, participation in grant writing, program evaluation, or program development, attendance at AuMHC sponsored training conferences and workshops, participation in the Training Committee meetings for the Center’s APA accredited pre-doctoral internship program, and the provision of didactic training in supervisory competencies to the psychology interns.

There are a variety of clinical populations with which residents may work, from pre-school children to older adults, refugees, medical patients in integrated care settings, developmentally disabled mentally ill adults, children in school settings, and individuals, families, and groups in multidisciplinary outpatient clinics. As part of their professional development, residents are required to select a specific population, or subset thereof, and to review the relevant literature related to the assessment and treatment of the identified population, and to apply evidence based practices to the treatment of these clients during the residency. For example, a recent resident chose to develop specialized competency in working with expectant and post-partum mothers in an OB-GYN clinic, and another resident gained expertise in working with adults who have both a serious mental illness and a substance abuse problem.

**Goals and Objectives of the Residency**

The overall goals of the residency are to help early career psychologists: (a) develop advanced knowledge and skills in the assessment and treatment of a diagnostically and culturally diverse client population; (b) meet all of the supervisory and clinical requirements for licensure eligibility in Colorado; and (c) solidify their identity as a professional psychologist and be prepared to practice independently and in leadership positions as clinical psychologists within community health settings.

By the conclusion of the residency, in order to meet the first goal related to assessment and treatment of a diverse client population, it is expected that residents will achieve the following objectives: demonstrate a thorough working knowledge of psychiatric diagnostic nomenclature and DSM classification; utilize historical, interview, cultural, and psychometric data to diagnose accurately; autonomously choose appropriate tests to answer referral questions; proficiently administer psychometric tests in her/his area of practice; skillfully and efficiently interpret test results; accurately interpret and integrate test results; write a well-organized psychological report; answer referral questions clearly and provide the referral source with specific recommendations; provide testing feedback in terms the patient and/or caregiver can understand and respond empathically to questions or concerns; use therapeutic interventions that are consistent with empirically supported treatments; and review literature and attain consultation to expand range of interventions with special populations such as young children, older adults, developmentally disabled, refugees, and medically compromised individuals.

In order to meet the second goal of being eligible for licensure as a psychologist in Colorado by the conclusion of the residency, residents will have accumulated 2,000 hours of practice, received at least 100 hours of individual supervision from licensed psychologists over a12 month period, and will have passed – or be prepared to pass- the EPPP.

In reference to the third goal of solidifying professional identity as an early career psychologist who is able to practice clinical psychology independently and be prepared for leadership roles in community health settings, residents will be expected to demonstrate professional interpersonal behavior such as having smooth working relationships and be able to resolve differences in an open, tactful and effective manner; use positive coping techniques to manage personal stress and thus maintaining professional functioning and high quality client care; demonstrate compliance with documentation standards within required timelines; demonstrate good knowledge of ethical principles and state law; demonstrate an ability to accomplish administrative tasks in a timely and professional manner; demonstrate a high level of self-awareness and to recognize and respectfully account for differences between self and others as it relates to cultural background and variances in values and beliefs; display necessary self-direction in gathering clinical and research information necessary to clinical practice; and demonstrate good knowledge and application of supervision skills.

**Expected Competencies**

In the specialty training area of Clinical Psychology, successful completion of the AuMHC post-doctoral program requires that residents demonstrate competency in the following areas:

1. Assessment and Diagnosis that is grounded in scientific theory and research. Training activities that will support the attainment of this competency include: conducting diagnostic intake evaluations; testing interviews, test selection and administration; test result interpretation and report writing.
2. Case Conceptualizations and Interventions that are empirically supported and use of outcome measures to guide the continuation or modification of the interventions. Residents will conduct individual, family, and/or group psychotherapy; review theoretical and intervention literature; develop treatment plans; and measure outcomes (e.g., outpatient teams use Scott Miller’s Feedback Informed Treatment – which is a SAMHSA approved evidence based practice).
3. Consultation that demonstrates knowledge of the relevant professional literature and which is informed by attention to individual and cultural diversity, ethical guidelines, and legal standards. Training activities that will support the attainment of this competency may include: testing feedback to clients/guardians; supervised experience consulting with other public and private human service and social service organizations (e.g. hospitals, medical clinics, schools, department of human services, probation department, and nursing homes); and collaboration with multidisciplinary staff in the development of treatment plans.
4. Grant Writing, Program Evaluation or Program Development which includes scholarly inquiry and the application of scientific knowledge. Each resident will engage in at least one of these activities, usually as a member of a team, and will work under the supervision of staff psychologists who have similar interests.
5. Interdisciplinary Collaboration with medical staff, social workers, counselors, and case managers which demonstrates good communication, effective team planning, and respect for the contributions and perspectives of other disciplines. All treatment teams are interdisciplinary and therefore practice in this area of competency is a daily occurrence, with formal collaboration taking place during weekly clinical team meetings. Additionally, residents who select rotations with either Integrated Care or the Refugee Wellness Center will consult and collaborate with primary care providers on a daily and ongoing basis. Residents who select training with the School-Based program provide consultation to teachers and school administrators. Residents who are placed with the Older Adults team will consult and collaborate with nursing home staff.
6. Professionalism and Reflective Practice as demonstrated by behaviors and values that adhere to professional standards and indicate ongoing attention to increasing self-awareness and knowledge, including through the use of supervision and consultation. Supervisors will support, monitor, and evaluate the professional deportment and self-awareness of residents, and as appropriate utilize the observations and feedback from other staff members who regularly interact with the residents.
7. Knowledge, sensitivity, and skill in working with individuals, groups, and communities that are representative of Individual and Cultural Diversity. Based on the number of languages spoken in the public schools, Aurora is considered one of the most culturally diverse cities in the United States. Residents have abundant opportunities to assess and treat Latino, African American, and Caucasian individuals and families, and refugees from Asia, Africa, and the Middle East. Residents may choose to co-facilitate support groups for the LGBT community. Residents expand their knowledge of individual and cultural differences by reviewing the literature and receiving supervision and consultation.
8. Ethical and Legal Practice that is demonstrated by the knowledge and application of APA ethical principles and standards of practice, and Colorado mental health law in decision making and practice implementation. Ethical dilemmas and legal standards are reviewed during supervision and case conferences.
9. Knowledge and teaching of Supervision roles, models, and procedures to pre-doctoral psychology interns. Residents assist in facilitating the Supervision of Supervision group that is conducted for the pre-doctoral interns. Residents review theories and research on supervision and delineate the supervision competencies that are required for good practice. Residents apply this knowledge and skill in their provision of supervision to graduate practicum students.

**Rotation Descriptions**

As described below, there are a variety of clinical populations with which residents may work, from early childhood to older adult, refugees, medical patients in integrated care settings, developmentally disabled mentally ill adults, children in school settings, and individuals, families, and groups in multidisciplinary outpatient clinics. To build caseloads, residents in outpatient programs initially work at least one day per week in one of the Connect to Care clinics, which is the access point for outpatient services and where most initial diagnostic intake evaluations are conducted.

Connect to Care (Required experience for outpatient programs, ranging from one day per month to a Minor Rotation)

Connect to Care (C2C) consists of two clinics, one in North Aurora and the other in South Aurora. C2C is the access point for members of the community to receive information and services from Aurora Mental Health. Each C2C is staffed by a manager, lead clinician, case managers, and by outpatient clinicians who rotate at a clinic one day per week. Services provided in the C2C include answering phones, conducting initial and short-term follow-up therapeutic services, diagnostic intake evaluations, medication services, case management, psychoeducation, and referrals to the AuMHC outpatient and specialty clinics, as appropriate.

Southeast Adult Outpatient Clinic (Optional Primary or Minor Rotation)

The Southeast Team provides mental health treatment and education to individuals, couples, and groups who are seeking help for a variety of problems. Services include intake evaluations, psychotherapy (individual, couples, and group), crisis intervention, psychological testing, case management, consultation, and medication management. The multidisciplinary staff includes psychologists, psychiatrists, clinical social workers, counselors, and a nurse. Most clients are between 18 and 69 years old and have presenting problems that range from adjustment disorders to severe and persistent mental illness. A variety of Evidence Based Therapies are applied, including CBT, DBT, and ACT. Therapy groups that are currently being conducted include Mind Over Mood, Acceptance and Commitment Therapy, Trauma Support, Mind-Body Wellness, Stress Management, and Hearing Voices. The Southeast facility is located in a predominantly middle-class area of Aurora, and while the clients present with a broad spectrum of problems, they are generally functioning at a higher level and have more resources than clients who live in other parts of the city.

Older Adults Outpatient Services (Optional Primary or Minor Rotation)

The Older Adults Team provides psychotherapy and education for older persons and their families who are experiencing mental health or adjustment to aging problems. Services are provided at both the Southeast (primary) and North clinics, as well as in nursing homes and assisted living facilities. Psychologists conduct neuropsychological screening. PASSR evaluations are conducted to determine appropriateness for nursing home placement. The treatment team consists of two psychologists, a social worker, and the psychiatrists, nurse practitioners, and nurse that are integrated into the two adult outpatient teams (Southeast and North Adult).

Community Living Program (Optional Primary Placement)

Community Living Program (CLP) is an intensive outpatient treatment program that provides a range of therapeutic services including individual therapy, group therapy, crisis intervention, case management and medication management. This intensive outpatient program is available for clients needing several hours of therapeutic interventions per week as well as frequent individual therapy to facilitate their stability and recovery. This program serves clients with high risk behaviors and clients needing intense therapeutic services to avoid hospitalization. Clients in this program present with a diverse array of problems including severe and persistent mental illness, personality disorders, and PTSD. The multidisciplinary staff includes a psychologist, psychiatrists, clinical social workers, counselors, case managers, and nursing staff. Clinicians also collaborate and coordinate treatment needs of clients with medical providers at a primary care clinic (MCPN) that is co-located within the same office building.

Aurora Center for Life Skills (Optional Primary Placement)

**Aurora Center for Life Skills** (ACLS) is an outpatient program which offers a range of treatment options including assessment, diagnosis, intensive outpatient, individual and group therapy, case management, medication management and psychosocial rehabilitation. Treatment is specialized and adapted to meet the needs of individuals with a developmental disability to assist them with managing mental health symptoms. Additionally, the program is able to provide consultation and treatment for individuals with a TBI, as well as behavior therapy consultation and education to those within the developmental disability system who do not meet criteria for a mental health condition.

Child and Family South Outpatient Services (Optional Primary or Minor Rotation)

The multidisciplinary staff members on this team provide individual, group, and family therapy services to children and families. The clients seen on this team are culturally diverse and residents have the opportunity to work closely with families and schools to identify and treat a variety of symptoms and presenting problems. The groups offered by the team vary but may include: social skills play group, middle school group, teen group, boys group, girls group, divorce group, multifamily drumming group, and relaxation group. Team members utilize a variety of evidence based practices in their work including CBT, TF-CBT, CPS (Collaborative Problem Solving), EMDR and DBT. Some evening work is required.

Child and Family North Outpatient Services (Optional Primary or Minor rotation)

The Child and Family North Team provides individual, group and family therapy to children and families for a variety of problems including ADHD, parenting issues, anxiety, complex trauma, suicidal ideation and psychosis. This team serves a highly diverse group of children and families from many racial/ethnic groups including a large Latino population (with many Spanish speaking families) and multiple refugee communities. The groups offered by the team vary but may include: social skills play group, middle school group, teen group, boys group, girls group, divorce group, and DBT group. Team members utilize a variety of evidence based practices in their work including CBT, TF-CBT, and DBT. Some evening work is required.

Many of our clients are underserved and have Medicaid.

School-Based Program (Optional Primary or Minor Rotation)

The school-based program includes two teams – School-based North and School-based South. These teams provide comprehensive mental health treatment for school age children in elementary, middle, and high school settings in addition to three school-based primary care clinics affiliated with Rocky Mountain Youth Clinics. Services include intake evaluations, individual, group, and family psychotherapy, crisis intervention, consultation and case management. The youth served have a range of presenting problems; however many children have a significant trauma history. There is often a high concentration of Spanish speaking families in the School-based North program. Residents on this rotation have the possibility of working with the HEARTS (Healthy Environments and Response to Trauma in Schools) team which supports and educates schools in building trauma-sensitive practices to support children and families in communities affected by trauma.

Elmira Outpatient Team (Optional Primary or Minor Rotation)

The Elmira Outpatient Team is located in North Aurora, in a predominantly low income area. The client population is very diverse, and includes a large number of Latino clients as well as refugees from around the world who are referred by the adjacent Colorado Refugee Wellness Center. The program serves clients between the ages of 5 and 69. Services include individual, couples, family, and group therapy, case management and consultation.

Early Childhood and Family Center (Optional Primary Placement).

ECFC provides comprehensive mental health treatment for infants and children up to age 6. Many of these children have been victimized, traumatized, abused, abandoned, or have experienced emotional or behavioral difficulties which interfere with learning and developing relationships. Individual, family, and group therapies are integrated to best serve the needs of each child and family. A variety of parenting classes for new and teen parents are offered.  The program uses a number of Evidence Based Treatments including Parent-Child Interactional Therapy, Child-Parent Psychotherapy, The Incredible Years, Nurturing Parenting Program, Trauma Focused – CBT, and Relational Assessments.

Integrated Primary Care (Optional Primary or Minor Rotation)

Post-Doctoral residents have the opportunity to work as a part of a multi-disciplinary team of healthcare professionals serving underserved populations in one of two integrated primary/behavioral care clinics: Metro Community Provider Network (MCPN) - safety net clinics serving the Aurora community; and the Hope, Health and Wellness clinic providing innovative integrated care to AuMHC patients with serious mental illness through funding from the SAMHSA Primary and Behavioral Health Care Integration (PBHCI) initiative. Residents will assist in meeting the whole health person-centered needs of a diverse population presenting a wide range of medical and mental health conditions. Activities include: consultation with medical staff and patients, short-term behavioral health treatment, referrals for additional mental health care, and may involve conducting groups. Residents can expect to increase their knowledge of medical conditions and their interface with mental health conditions, and to participate in the integrated care innovations taking place in Colorado, which is one of the states leading the way in integrated care. We have multiple grants involving cutting edge innovations in the field, from which residents will have the potential to learn and participate.

Refugee Wellness Center (Optional Primary or Minor Rotation)

The Colorado Refugee Wellness Center offers a rare opportunity for residents wanting experience working with refugees from around the world. All newly arriving refugees in Aurora receive medical and mental health screenings through our refugee center. It is a collaboration between multiple partners, including Metro Community Provider Network, University of Colorado Department of Medicine, Aurora Mental Health Center and other community organizations involved in refugee healthcare. The refugee center is a culturally responsive integrated primary and behavioral health clinic, with wrap around services offering refugees multiple resources in a single location. It utilizes health navigators as interpreters, cultural brokers, and care coordinators. Residents will have the opportunity to participate in cultural trainings, and get experience working with interpreters and staff who are multidisciplinary and from diverse cultures. They will learn how to do mental health screenings including the use of a culturally sensitive assessment tool, provide consultation to medical staff, and conduct short-term holistic integrated care with refugees, which addresses both physical and mental health. Since many of the refugees have also experienced trauma, a trauma-informed orientation is utilized. In addition to psychology interns and residents, the refugee center is also a training site for medical residents. Opportunities to participate in grant research are often available for interested residents.

**Supervision and Mentorship**

Residents are assigned a primary clinical supervisor, who is an experienced licensed psychologist. The resident and primary supervisor meet individually at least one hour per week throughout the training year. These meetings entail the discussion of cases and related clinical topics, reviewing progress in the program, and evaluating training needs. The resident has a minimum of one additional hour of weekly individual supervision in accordance with the current minor rotation with a licensed psychologist who is associated with the specific training site. The format of supervision may include case discussion, review of treatment notes, review of audio- or videotape, live supervision behind a one-way mirror, or co-therapy.

Residents attend and participate in the regular group supervision meetings and case conferences that occur on at least a weekly basis at their primary and minor rotations. In addition, residents attend a monthly case conference with the training director and/or other training staff. The focus of these cases conferences is assessment and treatment approaches with challenging clients and ethical or legal issues.

In addition to formal supervision, residents select a non-supervising psychologist to serve as a mentor. The role of the mentor is to provide the resident support and guidance in their professional development. For example, this could include discussion related to strategies to maintain work-personal life balance while meeting the requirements of the residency program, exploring career alternatives, and effectively managing the complexities of working with managers and supervisors who may have varying expectations and interpersonal styles. The resident-mentor relationship is non-evaluative. In order to facilitate the establishment of it being a “safe” relationship, communication with the mentor is considered confidential unless there are legal or ethical violations that require reporting. The resident and mentor may meet on- or off-site and they mutually determine the frequency in which they meet.

**Training Resources**

Residents have access to AuMHC testing materials to evaluate cognitive, emotional, and personality functioning in people of all ages. Some, but not all, of the clinics where fellows receive training have video recording equipment and one-way mirrors for live observation. Audio recording devices are available at each site. A variety of treatment manuals are available to fellows and training staff, such as The Skills Training Manual for Treating Borderline Personality Disorder, Overcoming Trauma Workbook, Building Motivational Interviewing Skills, Relaxation and Stress Reduction Workbook, and the Mind Over Mood Workbook. The training director has several APA and other training videos that are viewed and discussed with the residents, including Competency-Based Supervision, Critical Events in Psychotherapy Supervision, Mindfulness for Anxiety, and The Ten Principles of Effective Couples Therapy. Each of the child programs have a variety of toys, puppets, board games, and sand trays for play therapy.

Residents and training staff have the same clerical, technical, and electronic support that is

available to other clinical staff. Each facility where the fellows receive training has

administrative support staff to greet clients, answer phone calls, file, type letters and other

documents, collect client payments, order office supplies, and ensure the smooth day-to-day

operation of the clinics.

The Information and Technology (IT) department of AuMHC provides assistance with

computer and phone difficulties, both in person and through a help line. This department

ensures that each computer used by staff and residents is loaded with necessary software

programs such as Word, Outlook, Excel, and PowerPoint. In addition, residents have access to

the Aurora Research Institute (ARI), which is a subsidiary of AuMHC. The director of ARI

provides consultation on program evaluation projects conducted by the residents, and ensures

that the residents have access to SPSS.

During orientation, fellows receive approximately six hours of training on how to use the

Center’s electronic health record and electronic scheduling systems. Each AuMHC clinical

Office is equipped with a desk top computer and printer. When residents work off-site, such

as in a school or medical clinic, they are provided a laptop computer.

**Postdoctoral Residency Admissions, Support, and Initial Placement Data**

Financial and Other Benefit Support

|  |  |
| --- | --- |
| Annual Stipend for Full-time Residents | $40,000 |
| Annual Stipend for Half-time Residents | NA |
| Program provides access to medical insurance for resident?  Trainee contribution to medical insurance cost required?  Coverage of family member(s) available?  Coverage of legally married partner available?  Coverage of domestic partner available? | Yes  Yes  Yes  Yes  Yes |
| Hours of Annual Paid Personal Time Off (Vacation) | 96 |
| Hours of Annual Paid Sick Leave | 96 |
| In the event of medical conditions and/or family needs that require extended leave, does the program allow reasonable unpaid leave to residents in excess of personal time off and sick leave? | Yes\* |
| Other Benefits: additional $2,400 per year for residents who are able to conduct therapy in a second language or $4,000 per year if fluent in both English and Spanish; $15,000 in life insurance; professional liability insurance; long-term disability insurance; an EAP program; ten paid holidays; and an eco-pass which enables free passage on metro area RTD and light rail public transportation. |  |

\*The completion date of the residency is extended by the number of unpaid leave days taken.

**Initial Post-Residency Positions**

(Aggregated Tally for the Preceding 3 Cohorts)

|  |  |  |
| --- | --- | --- |
|  | 2015-2017 | |
| Total # of resident who were in the 3 cohorts | 6 | |
| Total # of residents who remain in training in the residency program | 0 | |
|  | PD | EP |
| Community mental health center | 6 | 5 |
| Federally qualified health center | 0 | 0 |
| Independent primary care facility/clinic | 0 | 1 |
| University counseling center | 0 | 0 |
| Veterans Affairs medical center | 0 | 0 |
| Military health center | 0 | 0 |
| Academic health center | 0 | 0 |
| Other medical center or hospital | 0 | 0 |
| Psychiatric hospital | 0 | 0 |
| Academic university/department | 0 | 0 |
| Community college or other teaching setting | 0 | 0 |
| Independent research institution | 0 | 0 |
| Correctional facility | 0 | 0 |
| School district/system | 0 | 0 |
| Independent practice setting | 0 | 0 |
| Not currently employed | 0 | 0 |
| Changed to another field | 0 | 0 |
| Other | 0 | 0 |
| Unknown | 0 | 0 |

Note: “PD” = Post-doctoral residency position; “EP” = Employed Position

**Additional Post-Doctoral Residency Outcomes**

Resident ID Year in Residency Passed EPPP CO Licensed

|  |  |  |  |
| --- | --- | --- | --- |
| Resident 1a | 2014-2015 | Yes | Yes |
| Resident 1b | 2014-2015 | Yes | Yes |
| Resident 2a | 2015-2016 | Yes | Yes |
| Resident 2b | 2015-2016 | Yes | Yes |
| Resident 3a | 2016-2017 | Yes | Pending |
| Resident 3b | 2016-2017 | Yes | Pending |

**Application Procedure**

The program accepts two post-doctoral residents per year. By the start of the residency, applicants must have completed all requirement for the doctoral degree from an APA Accredited doctoral program and have successfully completed an APA Accredited pre-doctoral internship. AuMHC is an Equal Opportunity Employer; individuals from diverse backgrounds are encouraged to apply.

Please submit the following through the APPIC affiliated online APPA CAS application portal (<https://portal.appicpostdoc.org>): a cover letter describing your interest in our program; vita; 3 letters of recommendation; a letter from your graduate program’s Director of Clinical Training and your internship Training Director attesting to your standing in the program and expected date of graduation; a redacted sample assessment report; and an official graduate school transcript. In addition, please answer the following questions in one to two pages: Please tell us about yourself. For example, what experiences influenced your interest in becoming a psychologist? What do you consider to be your greatest strengths and area(s) of relative weakness? What are your professional goals? What do you see as the role of a psychologist in community health settings?

The AuMHC post-doctoral residency program follows the guidelines set for by the Association of Psychology Postdoctoral and Internship Centers (APPIC), including adhering to the uniform notification date of February 26th unless the reciprocal offer option is invoked prior to this date.

Final appointment of applicants to the residency at Aurora Mental Health Center is contingent on matched applicants passing a criminal background investigation. This includes a name search through bureau of investigation units in states where the individual has lived for the past seven years. A search will also be conducted through the Department of Human Services. If adverse information is received, the applicant will be required to provide evidence of disposition. If an applicant has a drug-related offense, the individual will be required to provide evidence of disposition and may be required to submit to a drug screen upon hire and periodic drug tests. Each situation will be handled on a case-by-case basis. The Executive Director will make all determinations regarding any adverse action taken. Finally, all Center staff are required to get an annual flu vaccine.

The Center’s non-discrimination employment policy applies to the residency program. We are dedicated to the principles of equal employment opportunity in any term, condition or privilege of employment. We do not discriminate against applicants or employees on the basis of race, color, national origin (ancestry), gender, sexual orientation or expression, genetic testing, religion (creed), political affiliation, citizenship status, age 40 and over, size, genetic information, marital status, disability or military status, or any other status protected by state or local law, in any of its activities or operations. This prohibition includes unlawful harassment based on any of these protected classes.

The application deadline is December 29, 2017. The residency starts on September 18, 2018; however, occasionally we are able to provide a flexible starting date.

Questions can be addressed to:

Jeff Longo, Ph.D., Training Director

20971 East Smoky Hill Road, Suite 101

Centennial, CO 80015

[JeffLongo@aumhc.org](mailto:JeffLongo@aumhc.org)

(303) 617-2408

**Supervisors**

Sue Ammen, Ph.D., California School of Professional Psychology

Program Director, Early Childhood and Family Center

Play Therapy, Infant-Family Specialist, Assessment, Teaching

Kirsten Anderson, Psy.D., University of Denver

Division Director, Child & Family Outpatient Services and Disaster Coordinator

Disaster Response, Quality Assurance, Play Therapy, Group Therapy

Sarah Avrin, Ph.D., Washington State University

Division Director, Dual Disability Services

Developmental Disabilities, PTSD, Families and Couples, and Peer Specialist Training

Megan Brennan, Psy.D., Alliant University/California School of Professional Psychology

Program Director, School Based South Program

Child, Adolescent & Family Therapy, Trauma and Consultation with Educators

Margaret Charlton, Ph.D., ABPP, Washington University in St. Louis

Intercept Center

Mental Illness in Youth with Developmental Disabilities, Adapted Treatment, Law and Mental Health, Child Trauma, Disaster Response

Winnie Hunter, Ph.D., McGill University

Colorado Refugee Wellness Center

Refugee Mental Health, Trauma Focused Therapy and Somatic Experiencing, Multicultural Competence, and Integrated Health

Jan Jenkins, Ph.D., University of Colorado

Clinic Director, Colorado Refugee Wellness Center

Refugee Mental Health, Consultation to Medical Providers

Mara Kailin, Psy.D., Rutgers University

Deputy Director

Cross-Cultural Issues, Trauma

Jeff Longo, Ph.D., University of Virginia

Program Director, Smoky Hill Clinic

Clinical Supervision and Training, Couples Therapy, Suicide Prevention

Laura Lovato, Ph.D., University of North Carolina, Charlotte

Older Adults Team

Mindfulness and Self-Compassion, Chronic Pain and Illness, and Interpersonal Process.

Laura McArthur, Ph.D., University of Utah

Program Director, School Based North Team

Child, Adolescent and Family Therapy; Trauma-Based Interventions

Daniele Mohr, Ph.D., Colorado State University

Assessment Director

Assessment, Multiculturalism, and Supervision

Dawn O’Neil, Ph.D., University of Cincinnati

Community Living Program

DBT, Trauma, Emergency Evaluations, Women’s Issues, Feedback Informed Treatment

Shane Spears, Psy.D., University of Denver

Elmira Outpatient Team

Therapy and Assessment with Children, Adolescents, Adults and Families

Lauren Widman, Psy.D., Wheaton College

Early Childhood and Integrated Primary Care

Trauma-based Interventions across the Lifespan, Infant Mental Health, Immigrant and Refugee Behavioral Health Care.

Emma Williams, Psy.D., PGSP-Stanford Consortium

Older Adults Team

Perinatal Mood and Anxiety Disorders, Geriatric, Trauma, and Supervision

Jay Willoughby, Psy.D., University of Denver

Early Childhood & Family Center

Infant Mental Health, Dyadic Therapy, Pediatric Behavioral Health Consultation

**Didactic Schedule** (preliminary)

See Appendix A

**Evaluation Forms and Procedures**

See Appendix B

**Due Process Policies and Procedures**

See Appendix C

**Appendix A**

**Didactic Schedule** (sample)

**September:** 1) Learning the Electronic Health Record

2) Complete Relias Training related to HIPPA and Aurora Mental Health Center Policies

3) Introduction to Feedback Informed Treatment (FIT).

4) Read FIT Manual 1: Empirical Foundations

**October:** 1) Current opportunities for grant writing, program evaluation, and program development (staff presentations)

2) Core supervision competencies

3) Review clinical supervision competency literature

4) Integrated Primary Care Journal Club (optional)

**November:** 1) Colorado Mental Health Law (over two weeks)

2) Principles of Effective Couples Therapy

3) Case conference

4) Elective (e.g., post-partum depression)

5) Integrated Primary Care Journal Club (optional)

**December:** 1) Career exploration: working in Integrated Care settings

2) Preparing for the EPPP

3) Case conference

4) Elective (e.g., working with conflict during a family therapy session)

5) Integrated Primary Care Journal Club (optional)

**January:** 1) Involuntary treatment: ethical and legal considerations

2) Career exploration: Intensive Treatment VS Outpatient

3) Case conference

4) Elective (e.g., disaster response)

5) Integrated Primary Care Journal Club (optional)

**February:** 1) Building competence and confidence as a supervisor

2) Career exploration: The roles of program managers

3) Case conference

4) Elective (e.g., psychotherapy with LGBT clients)

5) Integrated Primary Care Journal Club (optional)

**March:** 1) Update on grant writing, program evaluation and program development project

2) The use of MyOutcomes to track client outcomes by clinician, team, and agency

3) Case conference

4) Elective (e.g., high conflict divorce)

5) Integrated Primary Care Journal Club (optional)

**April:** 1) Preparing for the EPPP

2) Career exploration: specialty practice VS general practice

3) Case conference

4) Elective (e.g., religious and spiritual issues in therapy)

5) Integrated Primary Care Journal Club (optional)

**May:** 1) Ethical dilemmas in managed care

2) Preparing for employment: resume construction and interviewing tips (2 weeks)

3) Case conference

4) Elective (e.g., activation and installation of mindfulness practice in everyday life)

5) Integrated Primary Care Journal Club (optional)

**June:** 1) Critical incidents in supervision

2) Career exploration: senior management

3) Case conference

4) Elective (e.g., mindfulness for anxiety)

5) Integrated Primary Care Journal Club (optional)

**July:** 1) Preparing presentation of your grant/program eval/program development project to management

2) Transitioning from resident to early career psychologist

3) Case conference

4) Elective (e.g., assessment of autism spectrum disorders)

5) Integrated Primary Care Journal Club (optional)

**August:** 1) Issues related to being an early career supervisor

2) Case conference

3) Developing confidence as a supervisor

4) Integrated Primary Care Journal Club (optional)

**Appendix B**

Evaluation Forms and Procedures

**PROCEDURES FOR EVALUATIONS AND REMEDIAL ACTION**

**Evaluations**

1. General Policy

The goals of the evaluative process are: 1) to assure that the residency is providing the environment necessary to accomplish the overall goals of the program, and to insure that residents grow in confidence and competence to the point of being able to ethically and effectively practice psychology independently; and 2) to evaluate the goals through ongoing assessment of resident clinical skill development and competence. The residency program strives to make evaluation an open, two-way process.

1. Semi-Annual and Final Evaluations by Supervisors

Residents will receive end of rotation, six-month written evaluations by their minor rotation supervisors, and written evaluations at six months and at the end of the residency by their primary supervisor. Supervisors also provide ongoing verbal evaluations of each resident’s progress via weekly scheduled supervisory sessions. These sessions as well as input from other team members become the basis for the written evaluation by each supervisor. These evaluations focus on the resident’s progress toward attaining core competence and additional competencies, along with other professional development relevant to the practice of psychology.

4. Evaluation of Supervision by Resident

This evaluation is completed for each minor rotation supervisor by the resident at the end of the rotation, and for the primary supervisors at six and twelve months. The evaluation is intended to give the supervisor feedback on the effectiveness of his or her supervision.

5. Adverse Actions

As employees of the Residency Program at Aurora Mental Health Center, post-doctoral residents are expected to abide by all agency policies, regulations, and guidelines governing organizational practices and employee conduct. Alleged resident misconduct or violation of organizational practices will come under the jurisdiction of the Program. Residents are subject to corrective action, and are protected by due process.

Aurora Mental Health Center

Post-Doctoral Resident Competency Assessment Form

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rotation (circle): Primary, Minor 1, Minor 2

Dates covered by eval \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Training Placement/Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment Method(s) for Competencies

\_\_\_\_\_ Direct Observation \_\_\_\_\_ Review of Written Work

\_\_\_\_\_ Videotape \_\_\_\_\_ Review of Raw Test Data

\_\_\_\_\_ Audiotape \_\_\_\_\_ Discussion of Clinical Interaction

\_\_\_\_\_ Case Presentation \_\_\_\_\_ Comments from Other Staff

Competency Ratings Descriptions

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

Rating expected at completion of postdoctoral training. Competency attained at licensure level, however as an unlicensed trainee, supervision is required while in training status.

**I Intermediate/Occasional supervision guidance needed.**

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

**U Unsatisfactory/Should remain a focus of supervision**

Performance is below expectations. Close supervision and a Remediation Plan are required.

**NA Not applicable for this training experience/Not assessed during training experience**

# Goal #1: Competence in Professional Conduct, Ethics and Legal Matters

**Objective A: Professional Interpersonal Behavior**

**Professional and appropriate interactions with treatment teams, peers and supervisors.**

**A** Smooth working relationships, handles differences openly, tactfully and effectively. Makes high quality contributions in team meetings.

**I** Actively participates in team meetings. Appropriately seeks input from supervisors to cope with rare interpersonal concerns with colleagues.

**U** May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.

**Objective B: Seeks Consultation/Supervision**

**Seeks consultation or supervision as needed and uses it productively.**

**A** Actively seeks consultation when treating complex cases and working with unfamiliar symptoms.

**I** Open to feedback, shows awareness of strengths and weaknesses, uses supervision well when uncertain, occasionally over or under-estimates need for supervision

**U** Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.

**Objective C: Uses Positive Coping Strategies**

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

**A** Good awareness of personal and professional problems. Stressors have only mild impact on professional practice.

Actively seeks supervision and/or personal therapy to resolve issues.

**I** Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact.

**U** Personal problems can significantly disrupt professional functioning. Needs ongoing and significant supervision time to minimize the effect of stressors on professional functioning.

**NA**

**Objective D: Professional Responsibility and Documentation**

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

**A** Maintains complete records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.

**I** Maintains timely and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.

**U** Needs considerable direction from supervisor. May leave out crucial information. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.

**Objective E: Efficiency and Time Management**

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

**A** Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.

**I** Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner, but needs occasional reminders.

**U** Highly dependent on reminders of deadlines. Frequently has difficulty with timeliness. Or tardiness or unaccounted absences are a problem.

**Objective F: Knowledge of Ethics and Law**

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

**A** Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgment is reliable about when consultation is needed.

**I** Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.

**U** Often unaware of important ethical and legal issues and/or disregards important supervisory input regarding ethics or law.

**NA**

**Objective G: Administrative Competency**

**Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.**

**A** Independently assesses the larger task to be accomplished, breaks the task into smaller ones and develops a timetable. Prioritizes various tasks and deadlines efficiently and without need for supervisory input. Makes adjustments to priorities as demands evolve.

**I** Identifies components of the larger task and works independently on them. Needs some supervisory guidance to successfully accomplish large tasks within the timeframe allotted. Identifies priorities but needs input to structure some aspects of task. Receptive to supervisory input to develop own skills in administration.

**U** Trainee takes on responsibility, then has difficulty asking for guidance or accomplishing goals within timeframe or deadline passes without task being done.

**NA**

Examples of resident performance for Goal #1

Goal #2: Competence in Individual and Cultural Diversity

**Objective A: Patient Rapport**

**Consistently achieves a good rapport with patients.**

**A** Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.

**I** Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success. Actively developing skills with new populations.

**U** Has difficulty establishing rapport. Alienates patients or shows little ability to recognize problems.

**Objective B: Sensitivity to Patient Diversity**

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

**A** Discusses individual differences with patients when appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.

**I** In supervision, recognizes and openly discusses limits to competence with diverse clients. Has significant lack of knowledge regarding some patient groups, but resolves such issues effectively through supervision and readings. Open to feedback regarding limits of competence.

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

**Objective C: Awareness of Own Cultural and Ethnic Background**

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

**A** Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.

**I** Aware of own cultural background. Uses supervision well to examine this in psychological work. Readily acknowledges own culturally-based assumptions when these are identified in supervision.

**U** Has little insight into own cultural beliefs even after supervision.

Examples of resident performance for Goal #2

Goal #3: Competence in Theories and Methods of Psychological Diagnosis and Assessment

Objective A: Diagnostic Skill

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

**A** Demonstrates a thorough knowledge of psychiatric classification, including relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.

**I** Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accuracy is typically good. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses. Requires supervisory input on most complex diagnostic decision-making.

**U** Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM criteria to develop a diagnostic conceptualization.

**NA**

**Objective B: Psychological Test Selection and Administration**

**Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered. Demonstrates competence in administering intelligence and personality tests.**

**A** Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question.

**I** Occasional input needed regarding fine points of test administration. Occasionally needs reassurance that selected tests are appropriate or periodically requires redirection of initially selected tests.

**U** Needs continued supervision on frequently administered tests. Needs regular consultation regarding appropriate tests to administer. OR test administration is irregular, slow. May often need to recall patient to further testing sessions due to poor choice of tests administered.

**NA**

**Objective C: Psychological Test Interpretation**

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

**A** Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results prior to supervision session.

**I** Demonstrates knowledge of scoring methods, reaches appropriate conclusions with some support from supervision. Occasionally uncertain how to handle difficult patients or unusual findings.

**U** Significant deficits in understanding of psychological testing, over-reliance on computer interpretation packages for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.

**NA**

**Objective D: Assessment Writing Skills**

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

**A** Report is clear and thorough, follows a coherent outline and is an effective summary of major relevant issues. Relevant test results are woven into the report as supportive evidence. Recommendations are related to referral questions.

**I** Report covers essential points without serious error, may need polish in cohesiveness and organization. Readily completes assessments with minimal supervisory input, makes useful and relevant recommendations.

**U** Inaccurate conclusions or grammar interfere with communication. Or reports are poorly organized and require major rewrites.

**NA**

**Objective E: Feedback Regarding Assessment**

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

**A** Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to accommodate patient or caregiver needs.

**I** With input from supervisor, develops and implements a plan for the feedback session. May need some assistance to identify issues which may become problematic in the feedback session. May need intervention from supervisor to accommodate specific needs of patient or family.

**U** Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver. Or does not modify interpersonal style in response to feedback.

**NA**

Examples of resident performance for goal #3

Goal #4: Competence in Theories and Methods of Effective Psychotherapeutic Intervention

**Objective A: Patient Risk Management and Confidentiality**

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

**A** Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions are taken to manage patient risk situations are initiated immediately, then consultation and confirmation of supervisor is sought. Establishes appropriate short-term crisis plans with patients.

**I** Aware of how to cope with safety issues, continues to need occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Sometimes can initiate appropriate actions to manage patient risk, sometimes needs input of supervisor first. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. May occasionally forget to discussconfidentialityissues promptly.

**U** Delays or forgets to ask about important safety issues. Does not document risk appropriately. Makes inadequate assessment or plan. Does not remember to address confidentiality issues, needs frequent prompting. Fear may overwhelm abilities during patient crises.

**NA**

**Objective B: Case Conceptualization and Treatment Goals**

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

**A** Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations. Consistently sets realistic goals with patients.

**I** Reaches case conceptualization on own, recognizes improvements when pointed out by supervisor. Readily identifies emotional issues but sometimes needs supervision for clarification. Sets appropriate goals with occasional prompting from supervisor, distinguishes realistic and unrealistic goals.

**U** Requires ongoing supervision to set therapeutic goals aside from those presented by patient.

Responses to patients indicate significant inadequacies in theoretical understanding and case formulation. Misses or misperceives important emotional issues.

**NA**

**Objective C: Therapeutic Interventions**

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

**A** Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.

**I** Most interventions and interpretations facilitate patient acceptance and change. Many interventions and interpretations are delivered and timed well. Supervisory assistance needed for timing and delivery of more difficult interventions.

**U** Needs supervision to plan interventions and clarify interpretations. Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.

**NA**

Objective D: Effective Use of Emotional Reactions in Therapy (Countertransference)

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

**A** During session, uses countertransference to formulate hypotheses about patient’s current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.

**I** Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Supervisory input is frequently needed to process the information gained. Welcomes supervisory input and can reframe own emotional response to the session.

**U** When feeling anger, frustration or other intense emotional response to the patient, tends to blame the patient. Unable to see countertransference issues, even with supervisory input.

**NA**

**Objective E: Group Therapy Skills and Preparation**

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

**A** Elicits participation and cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of cotherapist/supervisor with follow-up supervision later.

**I** Seeks input on group process issues as needed, then works to apply new knowledge and skills. Needs regular feedback concerning strengths and weaknesses. Generally prepared for group sessions. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.

**U** Has significant inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.

**NA**

Examples of resident performance for Goal #4:

Goal #5: Competence in Scholarly Inquiry and Application of Current Scientific Knowledge to Practice

**Objective A: Seeks Current Scientific Knowledge**

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

**A** Fully dedicated to expanding knowledge and skills, independently seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.

**I** Shows initiative, eager to learn, beginning to take steps to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor’s suggestions of additional informational resources, and pursues those suggestions.

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

**NA**

**Objective B: Participation in Grant Writing, Program Evaluation, or Program Development**

**Develops and implements plan for professional writing, research or presentation.**

**A** Develops plan alone or in conjunction with a colleague, supervisor, or mentor. Is a full and equal participant in the project.

**I** Provides substantive input into the plan. Demonstrates ability to execute at least one aspect of the project independently. Provides significant assistance in the accomplishment of the project.

**U** Does not follow-through with responsibilities in development or implementation of plan.

**NA**

Examples of resident performance for Goal #5

## Goal #6: Competence in Professional Consultation

Objective A: Consultation Assessment

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

**A** Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations with minimal supervisory input.

**I** Occasional input is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question. Requires occasional supervisory input regarding integration of findings and recommendations.

**U** Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.

**NA**

**NA Objective B: Consultative Guidance**

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

**A** Relates well to those seeking input, is able to provide appropriate feedback.

**I** Requires occasional input regarding the manner of delivery or type of feedback given.

**U** Needs continued guidance. May need continued input regarding appropriate feedback and knowledge level of other professionals. Or, has difficulty establishing rapport.

**NA**

Examples of resident performance for Goal #6:

## Goal #7: Competence in Supervision

**Objective A: Supervisory Skills**

**Demonstrates good knowledge of supervision models, techniques and supervision competencies. Effectively teaches this knowledge and information to intern class. As applicable, employs these skills in a consistent and effective manner, seeking consultation as needed.**

**A** Conducts thorough review of the supervision literature. Summarizes the literature to the intern class in a manner that is helpful, engaging, and well received. Interns verbalize appreciation of resident’s input in seminars and individual supervision, as applicable.

**I** Needs supervision to identify the core supervision competencies to teach interns. Organizes the information well with prompting. Receives positive feedback from interns for teaching and individual supervision, as applicable.

**U** Ineffective in teaching supervision information to interns. Supervisee reports supervision with resident to be unhelpful.

**NA**

Examples of resident performance for Goal #7

Supervisor Comments

Summary of Strengths

Areas of Additional Development or Remediation, including Recommendations

# Conclusions

Remedial Work Instructions

In the situation when it is recognized that a resident needs remedial work, a competency assessment form should be filled out **immediately**, prior to any deadline date for evaluation, and shared with the trainee and the director of training. In order to allow the trainee to gain competency and meet passing criteria for the rotation, these areas must be addressed proactively and a remedial plan needs to be devised and implemented promptly.

Goal for resident evaluations done at 6 months

(This includes the six-month evaluation for the primary rotation and the final evaluation for both minor rotations.)

All competency areas will be rated at a level of competence of **I** or higher. No competency areas will be rated as **U.**

Goal for final primary rotation evaluation

After 12 months, at least 75% of competency areas will be rated at **A** for the primary placement. No competency areas will be rated as **U.**

\_\_\_\_\_\_\_ The resident HAS successfully completed the above goal. We have reviewed this evaluation together.

\_\_\_\_\_\_\_ The resident HAS NOT successfully completed the above goal. We have made a joint written remedial plan as attached, with specific dates indicated for completion. Once completed, the rotation will be re-evaluated using another evaluation form, or on this form, clearly marked with a different color ink. We have reviewed this evaluation together.

Supervisor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trainee Comments Regarding Competency Evaluation (if any):

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

Trainee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AURORA MENTAL HEALTH CENTER**

**Post-Doctoral Resident’s Evaluation of Supervision**

Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rotation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates covered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the categories below, use the following scale to rate the extent to which your supervisor contributed to the development of your clinical knowledge, skills, and overall professional functioning. Indicate NA if the statement was not a part of your rotation or experience with this supervisor.

1 2 3 4 5 NA

Not at all A little Somewhat Mostly Completely Not applicable

**Professional Conduct, Ethics and Legal Matters**

1. \_\_\_\_The supervisor attended supervisory meetings promptly and reliably.
2. \_\_\_\_The supervisor was available for additional supervision time as needed.
3. \_\_\_\_The supervisor provided helpful guidance related to ethical issues.
4. \_\_\_\_The supervisor provided helpful guidance related to legal issues.
5. \_\_\_\_The supervisor provided helpful guidance related to risk issues such as child abuse/neglect, suicide, and homicide.
6. \_\_\_\_The supervisor contributed to the development of my clinical skills.
7. \_\_\_\_The supervisor helped me minimize the impact of stress on my professional functioning.
8. \_\_\_\_The supervisor expressed interest in the development of my professional identity as a psychologist.
9. \_\_\_\_The supervisor encouraged positive professional relationships with colleagues, including participation in team meetings.
10. \_\_\_\_The supervisor encouraged or allowed me greater autonomy, as appropriate for my capabilities and skills.
11. \_\_\_\_The supervisor fostered good communication, respect and trust.
12. \_\_\_\_The supervisor was a good role model.

**Individual and Cultural Diversity**

1.\_\_\_\_The supervisor displayed knowledge of diversity issues.

2.\_\_\_\_The supervisor prompted me to address diversity issues in the evaluation and treatment of my clients.

3.\_\_\_\_The supervisor helped me feel comfortable in discussing my cultural background and values.

4.\_\_\_\_The supervisor helped me understand the relevant cultural issues in working with client populations that I previously had little or no experience.

**Diagnosis and Assessment**

1.\_\_\_\_The supervisor helped me improve differential diagnostic skills.

2.\_\_\_\_The supervisor helped me to improve skills in test interpretation and integration.

3.\_\_\_\_The supervisor helped me improve skills in report writing.

4.\_\_\_\_The supervisor helped me to develop appropriate test report recommendations.

5.\_\_\_\_I was able to learn and use tests that I had not previously learned.

**Therapeutic Intervention**

1.\_\_\_\_The supervisor helped me improve my case conceptualization skills.

2.\_\_\_\_The supervisor guided me in using empirically supported interventions.

3.\_\_\_\_The supervisor helped me to become comfortable discussing my counter-transference to clients.

4.\_\_\_\_Supervison helped me to develop my group therapy skills.

5.\_\_\_\_Supervision helped me to develop my couple’s and/or family therapy skills.

**Application of Science to Practice**

1.\_\_\_\_Supervision helped me to apply current professional literature and research findings to my practice.

2.\_\_\_\_The supervisor was supportive of my participation in seminars, workshops, the grant writing/program evaluation/program development project.

**Professional Consultation**

1.\_\_\_\_The supervisor provided helpful guidance in my consultation with external collaborators such as primary care physicians, caseworkers, teachers, and probation officers.

2.\_\_\_\_The supervisor provided helpful guidance in my consultation with internal staff such as psychiatrists, therapists, and case managers.

**Supervision**

1.\_\_\_\_Contributing to the intern supervision of supervision seminar was a good learning experience that helped me expand my understanding of supervision competencies.

2. \_\_\_\_Providing supervision was a positive experience that contributed to my professional development.

**Supervisor’s Strengths:**

**Recommendations for Supervisor’s Improvement**:

Signature of Resident\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Supervisor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX C**

**DUE PROCESS POLICY & PROCEDURES**

**Remedial Actions**

The training director and supervisors strive to keep residents informed as to the quality of their performance while in training.

1. Should a resident be functioning at a level of “Unsatisfactory” according to the rating criteria utilized on the Post-Doctoral Resident Competency Assessment Form, the supervisor and training director will take the following measures:
2. Inform the resident of the identified problem areas(s).
3. Formulate a contractual agreement with the resident to rectify the problem areas(s). The contractual agreement will contain a minimum of the following elements:
4. Definition or description of the problem area(s).
5. Identification and description of specific behaviors comprising the problem area(s).
6. Specific recommendations for rectifying the problem area(s).
7. Criteria established to determine if the problem area(s) have been rectified.
8. Procedures to be utilized to evaluate the resident’s performance.
9. Time period for meeting criteria.
10. Should a resident not satisfactorily complete the requirements of the remediation contract, the following measures will be taken:
11. The training director will convene a meeting with the post-doctoral supervisors to discuss the rating and determine what action might be taken to address the issues reflected by the unsatisfactory resolution of the remediation contract.
12. The training director will advise the resident, in writing, of the date and time of the supervisors’ meeting. The meeting will be held within ten (10) working days of the date of written notification to the resident.
13. The resident will have seven (7) working days from the date of notification of the meeting to respond in writing to the rating and submit any materials on his or her behalf. The resident may also request to personally address the training director and supervisors.
14. Upon review of the unsatisfactory resolution of the remediation plan and any response by the resident, the training staff may act in accordance with the following notifications:
15. Notice of No Further Action: The staff has determined that no further action with respect to the unsatisfactory performance is indicated. The resident will be permitted to continue with the training sequence. The training director will provide the resident with a copy of the staff’s determination.
16. Notice of Acknowledgment: This action consists of the following elements:
17. A statement that a problem exists with respect to the resident’s performance, as reflected by the performance rating.
18. Identification of the problem behaviors associated with the rating.
19. A statement that the resident’s current and future supervisors will be apprised of the rating, and identified problem area(s) and behaviors.
20. A statement that the training staff will closely monitor the resident’s next rotation activities with the expectation of improved performance.
21. A statement advising the resident that he or she may be placed on probation should the level of performance not improve.
22. Notice of Probation: This action indicates that a resident is at risk for termination from the post-doctoral training program.
23. The Notice of Probation will include a contractual agreement between the resident and training staff, comprised of the following elements:
24. Definition or description of the problem area(s).
25. Identification and description of specific behaviors comprising the problem area(s).
26. Specific recommendations for rectifying the problem area(s).
27. Criteria established to determine if the problem area(s) have been rectified.
28. Procedures to be utilized to evaluate the resident’s performance.
29. Time period for meeting criteria
30. If the problem area(s) have been rectified within the time period specified in the contractual agreement, the resident will be removed from probationary status. The resident will be advised, in writing, of termination of probationary status.
31. If the problem area(s) have not been rectified within the time period specified in the contractual agreement, the training staff may:
32. Continue probationary status for a specified period of time as the supervisors continue to monitor the resident’s performance. Upon completion of this extension of probation, the training staff will meet to re-evaluate the resident’s status.
33. If the problem area(s) have not been rectified during the original or extended probationary period, the training director may recommend to the Executive Director of Aurora Mental Health Center that the resident be terminated from the post-doctoral residency program. The resident may be suspended from all work activities at Aurora Mental Health Center once the training staff decides to recommend termination from the program.
34. If the Executive Director makes a determination that the resident be terminated from the training program, the Executive Director or his designee will advise the resident in writing of the Executive Director’s decision within five (5) working days of the determination.

**Appellate Review and Adjudication**

A post-doctoral resident may appeal any adverse decision or action taken by the training staff.

1. Appeal Procedures
2. The resident must file a written appeal with the training director within ten (10) working days from the date the resident received written notice of any training staff decision or action. The appeal should include a restatement of the reasons given by the staff for its decisions or actions, and why the decisions or actions should be reconsidered or withdrawn. To aid the resident in the appellate process, he or she will be provided access to all documentation used by the training staff in deriving its conclusions.
3. Upon receipt of the written appeal from the resident, the training director will appoint an Appellate Review Panel. The Panel will consist of the training director, two supervisory staff members selected by the training director, and two supervisory staff members selected by the resident.
4. The training director must convene the Appellate Review Panel within five (5) working days of receipt of the written appeal. The Panel, to be chaired by the training director, will be empowered to secure any and all materials and documents related to training staff actions or decisions under appeal, and to question persons who may have information helpful to the Panel in its deliberations. A simple majority will decide all decisions affecting the resident. The training director will cast a vote only in the case of a tie. In addition to the written appeal, the resident may make a personal appearance before the Appellate Review Panel to present oral and/or written testimony or may choose to submit written testimony in lieu of personal appearance.
5. The training director within five (5) working days following adjournment of the Panel will present the findings and recommendations of the Appellate Review Panel in writing to the Executive Director of Aurora Mental Health Center.
6. Final Adjudication

The Executive Director of Aurora Mental Health Center will respond to the Appellate Review Panel’s recommendations within five (5) working days of receipt of the report. The Executive Director may accept, modify, or overrule any and all of the Appellate Review Panel’s recommendations. Upon adjudication by the Executive Director, the training director will advise the resident, in writing, of the final decision.

**Expedited Formal Grievance Procedures**

The aforementioned procedures may be expedited in the case of extreme incompetence, an accumulation of incompetence, serious ethical and/or legal violations, or serious violations of Aurora Mental Health Center Policies and Procedures. Examples may include - but are not limited to - sexual harassment, discriminatory behavior, insubordinate or exploitive behavior, plagiarism, or engagement in illegal activities.

1. The resident may be placed on paid or unpaid administrative leave until the final determination is made.
2. The resident will be provided information, in writing, about the grievance that has been made against the resident.
3. The training director will convene a Review Panel within 10 days of receiving the complaint. The Panel will consist of the training director, two supervisors selected by the resident and two supervisors selected by the training director.
4. A review hearing will be conducted, chaired by the training director. The grievance will be heard, and the person making the grievance has a right to present whatever facts and information they have that is relevant to the grievance.
5. The resident may present at the hearing and provide whatever facts and information they deem appropriate to dispute or explain their behavior.
6. The Panel will review the evidence concerning the complaint, and may secure any and all relevant materials and documents, and question persons who may have information that would be helpful the Panel in its deliberations.
7. Within 5 days of the completion of the review hearing, the Panel will send a report to the Executive Director of Aurora Mental Health Center with its findings and recommendations.
8. The Panel’s recommendations to the Executive Director may include Notice of No Further Action, Notice of Acknowledgement, Notice of Probation, or Notice of Termination.
9. The Executive Director of Aurora Mental Health Center may accept, modify, or overrule any and all of the Review Panel’s recommendations. Upon adjudication by the Executive Director, the training director will advise the resident, in writing, of the final decision.
10. If the Executive Director finds in favor of the individual(s) who brought the grievance, this information will be communicated to all relevant State Boards of Examiners of Psychology.

**Resident Training Problem Procedures**

The post-doctoral training program at the Center is firmly committed to maintaining a positive working environment. It is the right and responsibility of the resident to report problems with training and/or supervision.

1. If a resident has a problem, it should be discussed with the immediate supervisor within five (5) working days. If the resident is not satisfied with the solution, or if it is inappropriate to go to the supervisor, the resident may go directly to the training director within five (5) working days.
2. If the resident is not satisfied with the supervisor’s attempt at a solution, the resident should request a meeting with the training director within ten (10) working days to resolve the issue.
3. If the problem is not resolved at this level, the resident may request the training director to convene a meeting of the training staff. The staff will meet within ten (10) working days to resolve the issue.
4. In the event a satisfactory resolution has not been reached, the resident should make a written appeal within ten (10) working days to the Executive Director. Within ten (10) working days, the Executive Director will respond to the written appeal. The Executive Director’s decision is final.

5. Grievance Procedures

A resident may file a grievance against any employee of the Center for alleged unfair treatment. For further information refer to Employee Handbook and/or contact the Center Human Resources Manager.

6. Sexual Harassment

A resident who feels sexually harassed should take the complaint directly to the Human Resources Manager or Executive Director. Complaints will receive attention, and if the facts warrant it, appropriate action will be taken against the offender.