

CAMBRIDGE HEALTH ALLIANCE

Psychology Division Training Manual

2023-2024

Psychology Division Training Manual 2023-2024

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February 21, 2023

Dear Psychology Interns, Fellows, and Practicum Trainees,

Welcome to Psychology Training at the Cambridge Health Alliance! We are excited to embark upon a new training year and hope that you are excited as well.

In the coming days and weeks, you will receive many streams of new information: faces, names, places, routines, roles, and responsibilities. We have created this handbook to provide you with a reference to basic, orienting information about psychology training. It is necessarily broad and most certainly incomplete. Nonetheless, we hope it will help create some sense of grounding in this initial phase of your new training year. Please note that updates to the handbook will be made periodically and posted to the Psychology Division Team Page.

We won't be surprised if you feel overwhelmed by all that is new to learn. The clinical work that you are about to begin requires significant intellectual and emotional energy. Most of us find that our curiosity about the mind/psyche, our commitment to science and service, and our passion for multicultural learning holds us together as an academic-clinical community. We encourage you to make the most of your relationships with your peers, colleagues, supervisors and teachers. Finally, we also encourage you to create space in your lives to break from your work: to rest, play, and rejuvenate.

Best wishes for the year ahead!

Marla Eby, Ph.D.
Co-Interim Chief of Psychology
Director of Postdoctoral Fellowship Training Program
Associate Director of Psychology and Psychology Training

Patricia Harney, Ph.D.
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Associate Director of Psychology and Psychology Training

Carolyn Conklin, Ph.D.
Director of Practicum Training Program

Accountable Care and the Cambridge Health Alliance

For many years, Massachusetts has been at the forefront of efforts to reform health care delivery, improve quality, and to increase access to health services.

As part of this effort, the Cambridge Health Alliance has become an Accountable Care Organization. As an Accountable Care Organization, the Cambridge Health Alliance is eligible to receive global payments from private, state, and federal insurers in exchange for providing integrated care to a community of patients in accord with the tenets of a patient centered medical home. The Psychology Division is active in shaping the work of the ACO. As the Cambridge Health Alliance proceeds in this direction, the model of care delivery in some of our sites includes greater integration between Psychiatry and Primary Care. As an example, outpatient psychiatry teams may affiliate with particular primary care sites. This will allow psychology interns even greater opportunities for collaboration between mental health and medical services. As part of this new initiative, the Cambridge Health Alliance also delivers additional specialty mental health services, attuned to quality, to meet in-house need. The Psychodynamic Research Clinic (a sub-service within the Adult Outpatient Service), which opened in September of 2009, is one model of a new care entity of this type. Psychiatry leadership has prioritized this endeavor with funding and staff resources. RISE, a prodromal psychosis clinic within the Adult OPD, is another example. Thus, Psychology leadership and psychology training are an integral part of the Accountable Care planning process.

Administrative and Technical Support

The Division of Psychology has a full time Program Administrator of Psychology Training, Fiona McKenzie. Her office is located in the 2nd Floor of the Macht Building, room 239. She is available to assist interns with administrative and technical questions and has the expertise needed to direct interns to other sources within the hospital as needed.

APA Ethical Principles of Psychologists and Code of Conduct

www.apa.org/ethics/code.html

The screenshot shows a Microsoft Internet Explorer browser window displaying the APA website. The address bar shows the URL <http://www.apa.org/ethics/code.html>. The page header includes the APA ONLINE logo and navigation links for HOME, SITE MAP, and CONTACT. The main heading is "ethics" with the American Psychological Association logo. A Google Custom Search bar is present. The main content area features the title "ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT" and a sidebar with links for PSYCHOLOGISTS, STUDENTS, and PSYCHOLOGY TOPICS. The main text includes a notice about the 2002 Code of Ethics, a link to the 2002 Code, and information about the 1992 Code. A footer section provides contact information for the APA Ethics Office.

APA ONLINE
HOME SITE MAP CONTACT

ethics
American Psychological Association

Google™ Custom Search GO

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

PSYCHOLOGISTS
STUDENTS
PSYCHOLOGY TOPICS

Looking for the 2002 (new!) APA Code of Ethics? The 2002 Ethics Code went into effect on June 1, 2003. View the 2002 Code online at <http://www.apa.org/ethics/code2002.html>

Guidelines for Ethical Conduct in the Care and Use of Animals

The fifth edition of the APA Publication Manual, published before the 2002 APA Ethics Code was approved, contains cites to the 1992 APA Ethics Code. [View the 1992 Ethics Code.](#)

A Statement on Services by Telephone, Teleconferencing, and Internet

Posted [here](#) are updates that will make your fifth edition of the APA Publication Manual consistent with the 2002 Ethics Code.

APA Ethics Committee Rules and Procedures

© 2007 American Psychological Association
Ethics Office
750 First Street, NE • Washington, DC • 20002-4242
Phone: 202-336-6930 • TDD/TTY: 202-336-6123
Fax: 202-336-5997 • [Email](#)
[PsychNET®](#) | [Terms of Use](#) | [Privacy Policy](#) | [Security](#)

Cambridge Health Alliance

WHAT WE ARE

From our website: <http://www.challiance.org/careers/careers.shtml>

An award-winning system that has been recognized nationally for community and academic excellence

An integrated health network that has three hospitals - Cambridge campus, Somerville campus, and Whidden campus - and more than twenty primary care practices

A comprehensive health provider that offers a wide variety of medical, surgical, and mental health programs

An academic leader that has affiliations with both Harvard Medical School and Tufts University School of Medicine, as well as several schools of nursing, including Boston College, Simmons College, and the University of Massachusetts

An important resource that works with and within its communities to identify and address health disparities

An employer of more than 4000 individuals from many fields who work together to provide the best patient care and improve the health of our communities

Applicants are considered for positions without regard to race, color, religion, sex, national origin, sexual preference, age, marital status, medical condition, disability, or other legally protected status.

Cambridge Health Alliance supports a drug free work environment.

Cambridge Health Alliance Code of Ethics

From our website: http://www.challiance.org/aboutus/ethical_guidelines.shtml

It is the policy of Cambridge Health Alliance to use consistent ethical guidelines in decision-making about patient care, employee relations and business practices.

General Principles

The best interests of our patients drive our decision-making.

We are dedicated to the principle that all patients, employees, physicians and visitors will be treated dignity, respect, and courtesy.

Honest, open communication characterizes all of our interactions with patients, employees, and the community.

We honor the diversity of our patients, staff, and community and create a culture in which all feel valued and respected.

We are committed to using a collaborative decision-making process in resolving difficult patient care issues which involves all appropriate parties.

We fairly and accurately represent ourselves and our capabilities.

We provide services to meet the identified needs of our patients and do not provide unnecessary services.

We continuously improve the quality of our medical care.

We maintain patient confidentiality.

We honor our commitments to patients, staff, and the community.

We hold ourselves to the highest standards in meeting and exceeding all of our professional standards and legal and regulatory obligations.

We continuously monitor our compliance with this code of ethics and provide training as needed to achieve these goals.

Significant Ethical Policy Issues and Examples

Patient Care Issues

Treatment decisions are made on a case by case basis. Our care decisions are based on the clinical status of our patients and on patient/family desire.

We work in partnership with our patients and, if appropriate, with their families.

We share information about patient needs and preferences, diagnostic and treatment opportunities, and the risks and alternatives to recommended courses of action.

Communication with families is guided by the wishes of our patients.

When unexpected consequences or errors occur which significantly impact patient well being, it is our duty to inform the patient and/or family of the probable cause.

We proactively develop systems to maintain patient and other information in a confidential manner, recognizing the special challenges created by the increasing use of electronic methods of storing and sharing information.

We provide patients and their families with multiple methods to share with us their issues and concerns.

All members of the health care team have independent duties to be sensitive to a patient's needs and desires and to report their perceptions to the physician in charge.

The physician will encourage such communication.

Workplace Issues

We openly share information with our staff and keep our promises to our employees.

We provide a safe workplace free from any form of discrimination or harassment.

We encourage staff to share any ethical issues that arise for them by providing both confidential and anonymous methods to communicate their concerns.

We recognize that conflicts will inevitably arise amongst those who participate in hospital and patient care decisions.

We seek to resolve all conflicts fairly and objectively.

Business Practices

We provide inpatient and outpatient services to persons regardless of their ability to pay or immigration status.

Decisions to divert or transfer a patient to another facility are made only upon patient request or when the patient's specific disease or condition cannot be safely treated at our facility.

Discharge decisions are based on the patient's medical condition and readiness for discharge. We work to ensure that patients are treated at the most appropriate level of care.

We maintain a compliance program designed to establish a culture that promotes prevention, detection and resolution of instances of conduct which do not conform to federal, state, and private health care program requirements.

We welcome patient or other payer questions about charges, Questions will be discussed and conflicts resolved without real or perceived harassment, using a fair and formal process.

As part of our process, we will disclose any potential conflicts of interest and take appropriate actions to assure integrity.

We review all marketing materials to ensure that our organization, services, and policies and procedures are stated to our community and patients accurately, clearly, and in a culturally appropriate manner.

Cambridge Health Alliance EEOC Policy

Policy Number: A-HRS-0026

Effective Date: April 8, 2009

Date Original Version of Policy was Effective: August 1, 2008

Date of Most Recent Review/Revision to the Policy: October, 2015

I. Purpose

To provide CHA's employees with a safe working environment that is free of harassment of any type and discrimination on the basis of race, color, religion, creed, national origin, ancestry, sex, age, qualified mental or physical disability, sexual orientation, genetic information, gender identity, any veteran status, any military service, any application for any military service, or any other category or class protected by federal, state or local laws.

II. Personnel

This policy applies to the Cambridge Public Health Commission and each of its subsidiaries (collectively, "CHA" or "Cambridge Health Alliance") and to all CHA employees; non-employed members of the Cambridge Health Alliance Medical and Allied Health Professional Staff; non-employed students, residents, fellows and other trainees; independent contractors; contracted or agency workers; volunteers; and members of the Board of Trustees. If any portion of this policy is inconsistent with either an applicable collective bargaining agreement or civil service statute, the applicable collective bargaining agreement or civil service statute, as it applies to permanent civil service employees, shall take precedence in defining CHA's rights and obligations with regards to that portion of this policy except to the extent that the provisions of such collective bargaining agreement or civil service statute are inconsistent with applicable law governing the subject matter of this policy. However, the invalidity or modification of a portion of the policy shall not affect the applicability of the policy as a whole.

III. Policy

A. Equal Employment Opportunity

The Cambridge Health Alliance is an equal opportunity employer. All employment decisions and personnel actions at CHA are administered without regard to race, color, religion, creed, national origin, ancestry, sex, age, qualified mental or physical disability, sexual orientation, genetic information, gender identity, any veteran status, any military service, any application for any military service, or any other category or class protected by federal, state or local laws. All employment decisions and personnel actions, such as hiring, promotion, compensation, benefits, and termination, are and will continue to be administered in accordance with, and to further the principle of, equal employment opportunity.

B. Harassment and Sexual Harassment

CHA has a fundamental commitment to treating its employees with dignity and respect. The support of equal employment opportunity includes the recognition that harassment of

employees on account of race, color, religion, creed, national origin, ancestry, sex, age (40 and above), qualified mental or physical disability, sexual orientation, genetic information, gender identity, any veteran status, any military service, any application for military service, or membership in any other category or class protected under the law will not be tolerated. All employees have the right to be free from slurs or any other verbal or physical conduct that constitutes such harassment. Conduct that denigrates or shows hostility or aversion toward an individual because of the above attributes, or those of his/her relatives or friends, constitutes harassment when it:

- Has the purpose or effect of unreasonably interfering with a person's work performance; or
- Has the purpose or effect of creating an intimidating, hostile, or offensive working environment; or
- Otherwise adversely affects an individual's employment opportunities.

Sexually harassing behavior, in particular, includes all of these prohibited actions as well as other unwelcome conduct, such as sexual advances, requests for sexual favors, and verbal or physical conduct of a sexual nature where: (a) submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of employment or as a basis for employment decisions; or (b) such advances, requests or conduct have the purpose or effect of unreasonably interfering with an individual's work performance by creating an intimidating, hostile, humiliating or sexually offensive work environment. These definitions include any direct or implied requests by a supervisor for sexual favors in exchange for actual or promised job benefits, such as favorable reviews, salary increases, promotions, increased benefits or continued employment, as well as any sexually-oriented conduct that is unwelcome and has the effect of creating a workplace environment that is hostile to male or female workers.

Examples of conduct that may constitute sexual harassment depending upon the totality of the circumstances, including the severity of the conduct and its pervasiveness, include the following:

- either explicitly or implicitly conditioning any term of employment (e.g., continued employment, wages, evaluation, advancement, assigned duties or shifts) on the provision of sexual favors;
- touching a sexual part of an employee's body;
- touching any part of an employee's body after that person has indicated, or it is known, that such physical contact is unwelcome;
- continuing to ask an employee to socialize on or off-duty when that person has indicated she or he is not interested;
- displaying or transmitting sexually suggestive pictures, objects, cartoons, or posters if it is known or should be known that the behavior is unwelcome;
- regularly using sexually vulgar or explicit language in the presence of a person if it is known or should be known that the person does not welcome such behavior;
- derogatory or provoking remarks about or relating to an employee's gender, sexual activity or sexual orientation;
- coerced sexual acts.
- inquiries into one's sexual experiences; discussion of one's sexual activities

IV. Procedure

Because CHA views unlawful harassment as a sensitive and serious offense, the responsibility to investigate complaints of such harassment has been assigned to Labor and Employee Relations in the Human Resources Department. Any employee that believes he or she has been the subject of harassment should report the alleged act as soon as possible. Such complaints may be made orally or in writing to the following individuals: the employee's supervisor or manager, service line leader(s), area's Senior Vice President or Labor and Employee Relations in Human Resources. Employees should not allow an inappropriate situation to continue by not reporting it, regardless of who is creating the situation. Please note that while this policy sets forth CHA's goals of providing a workplace that is free from harassment, the policy is not designed nor intended to limit CHA's authority to discipline or to take remedial action for workplace conduct it deems unacceptable, regardless of whether that conduct satisfies the legal definition of harassment.

Investigation:

An investigation of any complaint of harassment on any basis will be undertaken promptly. The investigation may include an interview with the employee making the complaint, with witnesses (if any), and with the person accused of the harassment. CHA will attempt to maintain confidentiality to the extent possible within legitimate conduct of an investigation and/or as required by law.

Retaliation:

Further, it is unlawful to retaliate against an employee for filing a complaint. CHA will not tolerate any such retaliatory conduct. If any employee believes that he or she has been subjected to retaliation for having brought a complaint or participated in an investigation of harassment, that employee is encouraged to report the situation as soon as possible to Labor and Employee Relations in Human Resources.

False Accusation:

CHA also recognizes that the question of whether a particular course of conduct constitutes discrimination or harassment often requires a factual determination, and that false accusations can have a serious detrimental effect on innocent persons. Therefore, if an investigation results in a finding that a person accused another of discrimination or harassment maliciously or recklessly, or the complaining employee made false accusations, that employee may be subject to appropriate corrective action up to and including termination of employment. Any employee who has been found to have engaged in harassment or retaliation prohibited by this policy will be subject to appropriate discipline, up to and including unpaid disciplinary suspension and/or termination from employment. CHA strongly encourages employees to bring concerns about possible sexual and other discriminatory harassment to the attention of their supervisor or manager, service line leader(s), area's Senior Vice President or Labor and Employee Relations in Human Resources. Employees may also direct inquiries or file a formal complaint with either or both of the government agencies responsible for enforcement of employment discrimination laws (set forth below). Using CHA's complaint process does not prohibit you

from filing a complaint with these agencies. Each of the agencies has a short time period for filing a claim (300 days).

The U.S. Equal Employment Opportunity Commission (“EEOC”)
475 John F. Kennedy Federal Building
Government Center
Boston, MA 02203
(617) 565-3200

The Massachusetts Commission Against Discrimination (“MCAD”)
Boston Office: One Ashburton Place, Room 601
Boston, MA 02108
(617)-994-6000
Springfield Office: 436 Dwight Street, Suite 220
Springfield, MA 01103
(413)-739-2145

Case Presentations Outside of the Cambridge Health Alliance

Case presentations outside of the Cambridge Health Alliance require prior authorization by both your Training Director and the Chief Psychologist. This guideline applies to class presentations, oral presentations at conferences or grand rounds, and also written work for publication. When in doubt, please request consultation. Ordinarily, such public presentation will require written consent from the patient in advance.

Audiotaped and written, identifiable clinical material shall not leave the CHA premises. All audiotapes are to be kept in the locked cabinet designated for this purpose.

Please review CHA policy “The Uses & Disclosures of PHI to Persons Involved in Patient’s Care,” available on Staff Net, for additional information about de-identified clinical material.

Diversity Resources for Staff and all Trainees

All trainees working in our public sector health system treat patients from a multitude of racial, ethnic, cultural, and socio-economic backgrounds. Trainees are able to work with patients whose primary language is other than those the intern may speak by accessing our interpreter service which has the capacity to engage over 62 languages. Trainees are placed in at least two clinical sites. As a safety net hospital for the Commonwealth of Massachusetts, the Cambridge Health Alliance provides care for people with severe and persistent forms of mental illness, for those with life challenges that often include significant physical illness, psychosocial stressors, poverty, and/or undocumented immigration status. This enables trainees to have broad exposure to a range of clinical and

social populations. Seminars such as Psychology in the Public, Cultural Psychiatry Grand Rounds, Outpatient Case Conferences, Child Therapy, Psychological Testing, Diversity Training Day and Grand Rounds and a high ratio of supervisory to clinical contact hours allows trainees the opportunity to design treatment interventions for their patients that are aligned with the research and theoretical literature and with the practicalities of providing care for patients whose problems and life circumstances are not fully represented within extant clinical models.

The Chair of the Department of Psychiatry's Diversity Task Force is a psychologist. In this role, the Chair of the Diversity Task force regularly offers research, theory, or clinical articles related to multiculturalism to the Department at large. Further, the Division of Psychology has utilized a multicultural consultant to review curricular offerings and make recommendations to instructional faculty with respect to their seminars. Clinical supervisors and intern supervisees also receive information on sponsoring effective discussions about multicultural issues in supervision. Department of Psychiatry faculty and trainees (including Psychology faculty and trainees) receive release time to participate in the annual Diversity Training Day. Finally, the Diversity Task Force Chair organizes a Minority Mentoring Program, whereby any trainee who self-identifies as a minority in any way is offered an opportunity for mentoring by a faculty member.

Goals and Objectives of the Cambridge Health Alliance Psychology Internship

The overarching goal of the CHA psychology internship is to prepare doctoral candidates in psychology to understand and treat persons suffering with a broad spectrum of emotional distress. We also aim to prepare our interns to be future leaders in clinical service and training. Using a scholar-practitioner approach, our curriculum emphasizes a biopsychosocial and cultural approach to clinical understanding and treatment. Our specific goals are fourfold. First, we aim to develop competency in diagnostic assessment of patients with severe and persistent forms of mental illness. Second, we aim to develop competency in the consultation, treatment planning, and conduct of individual psychotherapy. Third, we aim to develop competency in collaboration skills across disciplines. Finally, we aim to develop competency in working effectively within complex systems of care. Our objectives toward each goal are as follows. Interns will develop competence in psychological and psychiatric evaluations in outpatient settings, with particular attention to the assessment of risk. Second, interns will demonstrate competence in their ability to formulate clinical problems and develop appropriate treatment plans. Third, interns will demonstrate competence in their collaborative professional skills, working on interdisciplinary teams and with collateral treaters. Finally, interns will demonstrate competence in working with multidisciplinary staff and with the necessary communication tools for collaboration within a complex and distributed health care system. Please see (the link to our Training Manual) for an extended description of our goals and objectives.

Goals and Objectives for Postdoctoral Training at the Cambridge Health Alliance

The Clinical Psychology Training Program prepares Psychology Fellows in clinical psychology to understand and treat persons suffering with a broad spectrum of emotional distress. Using a scholar-practitioner model, our curriculum emphasizes a biopsychosocial approach to the understanding of people and values the use of psychotherapy and assessment. Our talented and multidisciplinary faculty teaches fellows in a variety of specialty areas through didactics and comprehensive individual and group supervision. With close faculty-trainee interaction, we provide a solid grounding in treatment and assessment that take into account ethnic and cultural influences. We also teach fellows to integrate a variety of treatment modalities while working with persons with an array of psychological problems, including persons diagnosed with major mental illness and severe personality disorders.

Since a major goal of Psychology Fellowship Training at the Cambridge Health Alliance is to further develop competency in a defined specialty, the specific goals and objectives of each fellowship track may vary. However, general goals for all postdoctoral fellows are as follows:

1. To develop a high level of competency in an identified clinical specialty area (such as psychodynamic therapy with adults, neuropsychological and psychological assessment, treatment of trauma, behavioral medicine, assessment and treatment of acute and severe mental illness in children and adolescents).
2. To engender a high level of professional identity and a sense of ethical responsibility, in preparation for independent practice.
3. To foster a sense of competence and collaborative skills in working with other health care providers.

In line with these goals, objectives for Psychology Postdoctoral Training include:

1. Fellows will demonstrate competence in conducting a variety of clinical interventions in their given specialty, including case formulation and treatment plans.
2. Fellows will demonstrate competence in manifesting professional and ethical behavior.
3. Fellows will demonstrate competence in working effectively with health care providers in a variety of disciplines both within and outside of the hospital setting.

Goals and Objectives for the Cambridge Health Alliance Psychology Practicum

The Psychology Practicum Training Program prepares advanced trainees for internship training. Using a scholar-practitioner model, our curriculum provides a solid grounding in culturally-informed biopsychosocial approaches for understanding and treating persons suffering with a broad spectrum of emotional distress. With ample supervision, close faculty-trainee interaction, and didactic instruction by faculty with expertise in various

areas of specialty, our training program aims to develop basic competency in the following areas:

1. Diagnostic and psychological assessment of persons with severe and persistent psychiatric conditions, including psychotic, affective, trauma, substance, eating, and personality disorders.
2. Consultation, treatment planning, and conduct of treatment as appropriate to the specific training site (e.g., individual, family, and group interventions on inpatient unit; individual psychotherapy on Primary Care Behavioral Health Integration service; etc.).
3. Collaboration skills across disciplines, within complex systems of care.

Graduation Criteria, Goals & Objectives for all Psychology Clinical Training Programs at the Cambridge Health Alliance

Administration:

- 1.) Successful completion of rotations as per evaluations of preceptors and supervisors. To meet criteria for graduation, trainees must receive mean ratings (across supervisors) of Solid Foundational Skills or above on each evaluation item. To meet criteria for graduation, any areas of skill that required remediation must be adequately improved per the Training Director with consultation with supervisors.
- 2.) Adequate attendance at and participation in didactic seminars as documented by course director evaluation. Trainees are permitted up to 2 absences per semester (Fall, Spring). The TD and instructors may require a demonstration of mastery over missed material (e.g., written or oral) for any additional absences. Trainees are expected to inform instructors of absences. Please note that both interns and fellows are expected to attend grand rounds on a regular basis.
- 3.) Clinical competence per supervisory and preceptor evaluations. See Benchmarks section for fuller explication of expected standards.
- 4.) Demonstration of responsible professional behavior in providing clinical and administrative documentation as required. Trainees are expected to abide by the Policy and Procedure manuals for each site in which they participate.
- 5.) Provision of continuous care for a variety of patients according to age and ethnicity over an extended period of time, as directed, with a variety of treatment modalities.

Knowledge as evidenced in supervisory evaluations and clinical documentation:

- 1.) Adequate mastery of major theories and viewpoints of psychopathology in adults including etiology, prevalence, diagnosis, treatment and prevention.

- 2.) Knowledge of basic concepts in conducting individual child and adult psychotherapy including forming an alliance, the use of empathy, appropriate interventions per intended goals, ability to ascertain progress and/or the lack thereof and respond accordingly, and the recognition of transference and counter-transference or other responses to the setting or patient that impact the clinical work.
- 3.) Knowledge of basic concepts in conducting couple or family psychotherapy where indicated including forming an alliance, the use of empathy, appropriate interventions per intended goals, ability to ascertain progress and/or the lack thereof and respond accordingly, and the recognition of transference and counter-transference or other responses to the setting or patient that impact the clinical work.
- 4.) Knowledge about the use, reliability, and validity of diagnostic screening tests including psychological and neuropsychological tests, to aid in diagnosis.
- 5.) Adequate knowledge of developmental theory and psychopathology.
- 6.) Familiarity with concepts of group process as required by rotation.
- 7.) Familiarity with the broad range of therapeutic approaches used to stabilize and ensure the safety of acutely ill patients in inpatient and outpatient settings.

Skills as evidenced in supervisory evaluations:

- 1.) Ability to conduct and document a diagnostic interview including an accurate history and mental status examination and to choose appropriate diagnostic tests.
- 2.) Ability to formulate a case using a bio-psychosocial model using all five DSM axes and to develop an adequate differential diagnosis.
- 3.) Ability to competently assess safety and arrange appropriate dispositions in the context of a crisis intervention.
- 4.) Ability to devise a comprehensive treatment plan and access the appropriate reasons.
- 5.) Ability to competently manage psychiatric symptoms in patients in a variety of settings.
- 6.) Ability to work collaboratively in teams and within systems.
- 7.) Ability to provide individual psychotherapy, couples treatment and/or family therapy as required by setting.
- 8.) Ability to collaborate with psycho-pharmacologists who provide psychopharmacologic treatment of patients.
- 9.) Ability to communicate psycho-educational information to patients and families.
- 10.) Experience in utilization review, quality assurance and performance improvement.
- 11.) Develop teaching skills on both inpatient units and outpatient teams in teaching about psychological skills and frames of reference to other health care professionals.

Attitudes as documented by supervisors who directly oversee the trainee's clinical work:

- 1.) Respectful and compassionate interactions with patients and their families.
- 2.) Respectful interactions with staff and colleagues.
- 3.) Timely and professional responsiveness to queries from the Chief Psychologist and Training Directors.
- 4.) Appropriate consultation and referral within and outside the treatment system.

- 5.) Ethical professional standards met (both APA and CHA)

Mysell Research and Lecture Day

Each year the Department of Psychiatry holds an annual Research Day and Lecture at The Joseph B. Martin Conference Center at Harvard Medical, 77 Avenue Louis Pasteur, Boston, MA. The purpose of the event is to encourage collaborative research efforts within the Department by allowing faculty members and trainees to learn about the work being conducted at the various affiliate hospitals. Psychology interns and fellows are eligible to submit posters for this event and for juried research prizes. The Cambridge Health Alliance will subsidize the cost of professional poster preparation for Psychology interns and fellows whose submissions are accepted. Psychology Interns' and Fellows' seminars will be canceled on Mysell Research Day. Interns and Fellows will be excused from clinical work that day and are expected to attend, whether or not they present their own research.

National Provider Identification (NPI) Number Interns, Fellows and Practicum Trainees

As of May 20, 2007, all providers (staff and trainees) seeing patients must have a National Provider Identification number. This number will stay with you throughout your professional careers as a psychologist.

Please apply for your NPI by logging on to <https://nppes.cms.hhs.gov> There is a toll-free number, [1-800-465-3203](tel:1-800-465-3203), listed on the website for all questions.

Please make sure you apply for the NPI number for individuals.

Have the number emailed to the Training Coordinator, malevin@challiance.org, by listing it as the office contact email. Enter the business practice location as CHA and use the Coordinator's address and phone number. Leave the mailing address as your own. If you already have an NPI number, you should change the business practice location to CHA.

Getting Started on a Psychological Evaluation in the Outpatient Department

by Maggie Lanca, Ph.D.

Director of the Neuropsychology and Psychological Testing and Training

Neuropsychological and psychological testing is conducted across multiple settings in our psychiatry department. The Neuropsychological and Psychological Assessment clinic (NAPA) is the outpatient adult testing clinic which receives referrals from all hospital departments. This clinic has neuropsychology postdoctoral fellows, a psychological assessment postdoctoral fellow, and a psychology intern. Trainees in NAPA conduct both outpatient testing as well as inpatient testing on the psychiatric and medical inpatient units. Psychological testing for adult patients is also conducted in the Psychiatric Transitions Service (PTS) and in the OPD by psychology interns. Pediatric psychological testing is conducted both in the outpatient child psychiatry division by psychology interns and on the child and adolescent inpatient units by psychology practicum students, psychology interns, and psychology postdoctoral fellows.

The specific psychological and neuropsychological testing protocols and procedures vary across the multiple settings where testing is conducted. Please refer to the testing clinic procedures and/or the testing supervisor for more specific procedures, but below are general guidelines about testing on the outpatient services. A general testing orientation will be scheduled in the first few weeks of training to review in greater depth these procedures and other procedures more specific to the testing setting.

General Protocol and Procedures for Outpatient Psychological Testing:

1. Once you receive the referral form, get in touch with the referral person immediately to let him/her know that you are testing his/her patient and schedule the appointment *within one week of receipt*. It is very important to make a testing appointment as soon as possible. Book the appointment through EPIC.
2. Schedule a room for testing and try to get testing done in one day – up to 3-4 hours (with breaks) or book for a next appointment in the following few days. It is NOT advised to drag testing over the course of weeks though one needs to use clinical acumen to assess whether a patient can tolerate testing in one day.
3. Get in touch with your testing supervisor. Make an initial supervision appointment prior to any case assignment to discuss with your supervisor how much you know about testing and establish a schedule and format of how you will be supervised. You should also discuss the battery you will administer and whether you want to add additional tests to answer the referral questions better.
4. Test batteries differ depending on the age of the patient, type of testing (psychological or neuropsychological), and referral questions. In general, a standard psychological battery for adults includes TAT and PAI or MMPI, and possibly the Rorschach. For children, a TAT (or Roberts) and PAI-A (for adolescents) and often the Rorschach is typical. You may also include other projective and objective tests as appropriate. Please check with your supervisor beforehand and refer to the separate handout provided at orientation with a list of psychological/neuropsychological tests available at CHA.
5. Scoring a test protocol can be time consuming, especially if you do not have a great deal of experience with testing. Supports for scoring will be provided by your testing

supervisor and through other venues which will be conveyed to you at a testing orientation. An electronic version of the RPAS manual is on the CHA internet account of the RPAS. Other scoring manuals will also be made available.

6. You have been given access by our IT department to our psychology testing server and in the first month of your training you will be provided with instructions on how to access and use it to score your tests. If you have any problems with the server, please contact Dr. Lanca.
7. Once you have completed the report with your supervisor please do the following:
 - a. Print a hardcopy of the report.
 - b. Copy the first page of the report on Cambridge letterhead.
 - c. Have your supervisor sign the report.
 - d. Place a signed copy in a manila folder with the report and ALL the testing raw data. The manila folder should be given to the service supervisor (at NAPA, PTS, child outpatient division or child inpatient divisions).
 - e. Upload the report to the patient's EPIC chart and send to your supervisor for electronic signature. Instructions will be provided to you on how to do this at the testing orientation.
8. When working on a draft report with your supervisor, please remove ALL HIPAA identifying information, use a pseudonym to refer to the patient (e.g., XX), and password protect your documents before emailing to your supervisor.
9. Whether your patient will be provided with a copy of the report is a clinical decision that you must make with your supervisor and possibly the referring clinician. If you decide that the report is too "sensitive" for the client and/or would cause "substantial harm or misuse or misrepresentation of the data" then you can provide a written summary to the client if he/she requests it. The referring clinician should also be made aware that the report will not be released to the client directly.
10. If you are testing in the OPD, make an appointment with the patient to discuss the results of the testing and book the appointment in EPIC. This appointment need not be longer than 45 minutes. Sometimes it is wise to have a joint feedback session with the patient's therapist, especially if you feel the information is sensitive and will be difficult for the patient to hear. You are also advised to communicate with the patient's therapist ahead of time and let them know what you are planning to say to the patient, so that the therapist can help you "couch" the information in the most optimal way. Remember to keep feedback short and concise. Do not overload the patient with information and be sensitive to the difficulty of receiving such information.
11. The specifics of billing through EPIC will be conveyed at site-specific testing orientations. More generally, billing for each evaluation needs to be done through EPIC. The billing units and codes are individual to each case and working with the appropriate supervisor or unit director will be important to ensure that insurance preauthorization and billing proceeds correctly.

If you have any further questions over the course of the year, please feel free to contact me. I am on email or phone me at 617-665-1218.

Policies and Guidelines on Due Process, Remediation and Dismissal from Psychology Training Programs

- 1.) If a matter of urgent concern arises involving clinical care of patients of professional behavior, then the appropriate Training Director collects information and provides feedback to the psychology intern, practicum student, or fellow. Documentation of the problem will occur immediately; a copy will be given to the trainee, intern or fellow and a copy will be placed in the training record.
- 2.) The Training Director is responsible for maintaining confidentiality in the evaluation process. Information will be shared among the Chief Psychologist, Associate Directors of the Psychology Training Program, and the Chair and Associate Chair of the Psychiatry Department, and/or those supervising, precepting or managing the trainee, intern or fellow who need to be aware of this information to ensure patient care and to meet ethical responsibilities.
- 3.) Written documentation of feedback and any necessary remedial actions are provided to the psychology trainee, intern or fellow and included in the training record. This shall occur no less frequently than at six-month intervals.
- 4.) It is assumed that the majority of concerns will be adequately and fairly dealt with between the psychology intern, practicum trainee, or fellow and the appropriate Training Director. The Training Director maintains responsibility for ongoing consultation with the Chief Psychologist and the chair and Associate Chair of Psychiatry. The modes of intervention available to the Training Director include:
 - a.) Active mediation between the trainee, intern or fellow and the faculty member, service, and/or supervisor with whom a concern has arisen.
 - b.) Reassignment of the trainee to another rotation, service, supervisor and/or seminar should the problem be seen as existing substantially within the service or faculty member.
- 5.) If the trainee does receive an unsatisfactory evaluation, a plan for remediation the trainee's performance is established between the intern and the Training Director. Methods may include:
 - a.) Increased supervisory contact with the Training Director and/or other faculty members.
 - b.) Appointment of a faculty member as an advocate in the program.
 - c.) Remediation plans with faculty, preceptors, supervisors and managers with a timetable for agreed upon tasks which may include:
 - *Increased supervisory contact

*Increased didactic work, self-study or tutorial

*Repetition of a particular rotation or didactic experience

6.) In the event of troubling developmental conflict, psychiatric difficulty, or impairment by alcohol or other substances, a referral for private care should be made for the trainee. Support for the trainee in the form of clinical coverage, or leave of absence will be offered by the program. As mentioned earlier, the Training Director's consultation with HR might result in a requirement of an evaluation by occupational health.

7.) In the event that an academic/professional or administrative problem has been documented by the Director, and consultation with faculty familiar with the trainee, intern or fellow confirms that a substantial problem that has not improved with remediation, then the Director must give the trainee, intern or fellow verbal and written notification of probation (including length of time and reasoning), proposed disciplinary action, and/or a contemplated delay in progression or expulsion. The trainee, intern or fellow will be immediately relieved of all clinical responsibilities.

In the event of an alleged administrative misconduct, should the intern disagree with the assessment or the suggested remedy, the situation should be reviewed sequentially by the Chief of Service, Chief of Psychiatry and Chief Executive Officer of the Alliance. An outside arbitrator may be used if all other reviews fail to resolve the situation. (Examples of such misconduct may include (but may not be limited to) gross boundary violations, clear violation of APA ethical code, multiple converging concerns expressed by supervisors, clear and consistent violation of Policy and Procedure Manuals of the clinic.)

Processing of Errors of Evaluation

At any point in the process, should a negative evaluation of a psychology trainee, intern or fellow's functioning be unsubstantiated or considered incorrect, all materials associated with such incorrect assessment will be removed from the trainee's training record.

Policies on Seminar Attendance within the Psychology Internship Program

Psychology Interns are expected to attend all required seminars as outlined by their Training Director. Attendance will be taken in seminars via a sign in sheet. Two absences are permitted within the Fall and Spring seminar seasons. If an intern misses more than two seminars, the instructor retains the right to require the intern to demonstrate mastery of material in other ways (e.g., individual meeting, written assignment).

Grievance Policy regarding Supervision, Caseloads, Peer Relationships and Team Relationships

The Training Director for each respective program maintains responsibility for monitoring the work environment as free from undue stress, harassment or discrimination. Situations may arise in which a trainee has a grievance with a staff member, the trainee is requested to first speak directly to the staff member to address the grievance. If this is not feasible for the trainee or does not resolve the matter at hand, the trainee is to discuss the concern with his or her preceptor and Training Director. Depending on the situation and concern, the Training Director may or may not be able to maintain the privacy of the concern with the staff member involved, but will consult with the Chief Psychologist, Department Chair of Psychiatry, CHA Attorney, and/or HR Department, as recommended by the Chief Psychologist and the Department Chair. The Training Director will work with the trainee to resolve the situation to mutual satisfaction in a manner that preserves the integrity of the training goals.

Under those circumstances in which a trainee is concerned about the well-being or professionalism of a peer, the trainee is asked to address the Training Director with the concern. In this instance, the Training Director will maintain confidentiality of the reporting trainee as he or she investigates the concern. Such investigation may include speaking with the trainee about whom there is a concern (while maintaining the anonymity of the reporting trainee), and consulting if needed with the Chief Psychologist, the Department Chair, the CHA Attorney, and/or HR Department.

Policies and Guidelines on Vacations

All interns, fellows, and practicum trainees should discuss vacation policies with their Program Director, Site Directors and Preceptors. The following general guidelines apply to all trainees:

1. Good clinical practice requires that you provide as much time as possible, no less than six weeks advance notice of vacation or professional time off.
2. In general, no vacation time can be taken in the first four weeks or last four weeks of the training year. Major hospital holidays are an additional benefit, but these must be used on the specified day, and not saved for future vacation time. A listing of hospital holidays for the current training year may be found on the Psychology Division Team Page. Please note that Psychology trainees do not have the floating Veteran's Day holiday.
3. Clinical coverage happens within discipline – all psychology trainees need to arrange coverage from within their training group. An intern away from CHA must arrange

another intern to cover cases; interns may not “cover themselves”. In the event of a professional day for all interns, either Dr. Harney or Dr. Eby will provide coverage.

4. Vacation requests should be made in writing via email to your Training Director and Clinical Leaders (site director and preceptors and coordinated with your team leader or attending, if applicable) and the Chief Psychologist where indicated.

Vacation policies and guidelines specific to interns:

1. Full time Interns receive 20 days off that may be used for any purpose (vacation, personal time, conferences and/or dissertation work). Two weeks of this time should be used between August and December, and the other two weeks should be used between January and the end of May. Interns on the Acute Services Track may not take vacation time between December 24th and January 2nd, with the exception of the major holidays (December 25th and January 1st). Two weeks should not be used consecutively.

2. Interns may not take vacation time during the month in which they terminate their training. This means that interns leaving CHA on June 30th of any given training year may not take vacation time during the month of June. The only exceptions to this are where the intern makes a special request in the context of an extraordinary circumstance.

Vacation policies and guidelines specific to fellows:

1. Full time Fellows receive a total of 20 days off that may be used for any purpose (vacation, personal time, conferences and professional enhancement). Scheduling consecutive weeks off requires the advance approval of your Training Director, Service Leaders, and the Chief Psychologist. In general, Fellows should not take vacation in the first and last month of their training period. All vacation plans must be approved by your Training Director and Service Leaders.

Vacation policies and policies specific to practicum students:

Practicum Trainees receive the equivalent of three training weeks of vacation (that is, three 24-hour, 20-hour, or 16-hour weeks). Trainees may not take vacation time in the first and last months of their training year. Vacation weeks may not be scheduled consecutively except by special permission from your Training Director, Service Leaders, and the Chief Psychologist.

Pregnancy and Parental Leave Guidelines

A maternity or parental leave of absence without pay will be granted for a period of up to 6 months after the date of delivery or adoption of a child. Earlier leave (without pay) for a pregnancy-related medical condition may be requested with proper documentation from a physician. In the event of a leave, Cambridge Health Human Resources must be notified so that an official leave letter can be sent, and arrangements can be made for health/dental contributions if any of the time is going to be unpaid.

Those who take an approved leave of absence must still satisfy the criteria for completion of a training program unless specifically exempted by the Training Director and the Chief Psychologist.

Please note that psychology trainees who have been working consecutively at the Cambridge Health Alliance for one year (i.e. second year Fellows) have leave policies that are covered by the hospital's Family and Medical Leave Policy (available on Staff Net) which supersedes Psychology Division policies.

Policies and Guidelines Regarding Precepting for Practicum Trainees, Interns and Fellows in the Adult and Child OPD (including specialty clinics and teams)

Preceptors within the Division of Psychology are psychologists working within a specific service site, whose duty it is to both monitor and mentor psychology trainees working at that site. Psychology preceptors represent the interests of Psychology training on service delivery teams.

Guidelines for this role include the following:

1. Psychology preceptors support the work of clinical team and that of psychology training by sitting in on the evaluations and/or treatment sessions conducted by practicum trainees and interns and by offering real-time consultation. Fellows may also receive real-time consultation from preceptors as makes sense in the context of their teams and clinics.
2. Preceptors may not normally function as ongoing psychotherapy supervisors of the trainee, intern or fellow at the training site without the approval of the Chief Psychologist.
3. Every trainee (including practicum trainees, interns and fellows) will be assigned at least one psychologist-preceptor who is responsible for the trainee's work at that site.
4. Psychology interns who spend substantial time in more than one site will have a psychologist-preceptor at each site.

5. The preceptor will meet individually one hour per week with each designated trainee or intern, and a minimum of one hour monthly with each fellow. Deviations from this formula must be discussed and approved by the Chief Psychologist.
6. Preceptors are also responsible for monitoring the clinical work of the practicum trainee, intern or fellow at the service site, including oversight of documentation, risk management, case management and billing procedures. Some of this oversight will involve collaborative coordination with Team Leaders and other Service Leaders.
7. Preceptors are also responsible for helping the practicum trainee, intern or fellow adjust to the work setting, and problem-solve difficulties through the training year that are specifically related to the site.
8. Preceptors are responsible for monitoring training at the service site by regularly contacting all supervisors who are supervising the work of the designated trainee, intern or fellow for that site, and receiving feedback from the supervisors about the work of the trainee at that site. Preceptors should also obtain feedback about the practicum trainee, intern or fellow's performance from the team leadership of the site. Procedures for doing so will be determined by the Chief Psychologist.
9. Preceptors are also responsible for evaluating practicum trainees, interns and fellows, using information obtained from other supervisors and team leaders, as well as their own observations. Required evaluations of preceptors and preceptees will be collated via electronic tools like New Innovations, as well as through periodic narrative summaries.
10. Preceptors will attend Preceptors meetings to be organized and coordinated by Training Directors.

Policies Specific to Psychology Interns on CHA Adult and Child Outpatient Psychiatry (OPD) Clinics and Teams 2023-24¹

Psychology Interns

- Seven of the ten psychology interns will be placed in the General Adult OPD (including Cultural-Linguistic Teams) and the Psychodynamic research clinic. The Weill Foundation Intern will be placed only on the Child Outpatient Team and the Psychodynamic research clinic. In addition, three HRSA-funding interns will be placed in the following clinics: Primary Care/NAPA, Primary Care/Adult OPD, Primary Care/School-based Clinic.
- Four Adult-Child Track interns will also be placed on the Child Outpatient team (Thursday or Friday) for their other half-time placement. The Weill Foundation intern will be placed on the Thursday Child team from July-Dec and the Friday Child team from Jan-June.
- Each intern has a psychology preceptor who will meet the trainee for 45-60 minutes per week.
- Clinical contact hours of the interns and fellow hours will be reported to the Team Leader. Psychology preceptors will work collaboratively with Team Leaders to ensure

¹ Occasionally, department or hospital parameters require some modification of training time expectations. When this occurs the Director of Psychology will provide an update to this document.

that trainees have balanced caseloads with respect to diagnosis, gender, ethnicity, risk status, in so far as this is possible.

- In the Adult OPD, interns on the Adult/Acute Services or HRSA/OPD track will carry 10 clinical hours. Interns on the Adult/Child track will carry 5-7 adult cases in the Adult OPD. Treatment frequencies may be every week or every other week, generally speaking.
- In the PRC, interns will carry 1 patient with a treatment frequency of twice weekly. An additional twice weekly patient may be picked up by the intern at the discretion of the Training Director.
- In the Child OPD, interns will carry 8 patients with an expected treatment frequency of once per week. The Weill Foundation intern, however, will carry 12 patients in the Child OPD, as the Child OPD constitutes the primary placement.
- In Primary Care Clinics, interns will schedule no more than 5 individual patient hours within an 8-hour day (this will include intakes and follow-ups). Within this 8-hour day, interns may also run up to 1 group and engage in warm-handoffs and/or case consultation.
- Within the School-based clinic, interns will schedule no more than 5 individual patient hours within an 8-hour day and engage in testing/risk assessments at the direction of their school-based preceptor.
- The clinical hours of the intern will not be reported to the Team as a whole but shared among the Team leader, preceptor, training director, and intern. The Chief Psychologist also periodically reviews intern clinical hours.
- Interns will maintain a weekly log of their clinical work that will be submitted to their Preceptor. Monthly summary logs will be submitted to the Internship Training Director.
- The number of biweekly clinical cases will be limited so that trainees and interns are responsible for a reasonable number of persons.
- In order to graduate from the Psychology Internship, Psychology Interns are expected to gain mastery in core competencies in assessment, psychotherapy, psychosocial interventions and in the use of supervision, consultation and interdisciplinary collaboration in accord with the policies in the Psychology Division Training Handbook (see Graduation Criteria).
- Interns will develop facility and expertise with constructing a clinical formulation for each patient with whom they have professional contact. These formulations will guide the work of all treatments.
- The Psychology Division has designated clinical contact hours per week for interns to conduct ongoing psychodynamic psychotherapy. Interns should expect to conduct other forms of therapy as recommended by Team leaders, preceptors, and supervisors. Dynamic psychotherapies can be adapted for use with those with severe forms of psychopathology whose care may include many other intervention components. Team leaders, preceptors and supervisors will collaborate on the assignment and monitoring of these cases.

- Interns will also conduct therapies and interventions that include cognitive-behavioral treatment, illness management, group therapy and other evidence-based methods.
- For those interns engaged in the VOV mini-rotation, they will carry two additional cases from the VOV. For those interns engaged in the Primary Care Clinic Mini-rotation, they are expected to engage in four clinical hours each week at the primary care clinic.

Psychology Internship Admission Criteria and Selection Procedures

The psychology internship accepts applications from September 1 through November 1 for the training year that begins the following June 30 (or the last business day of June). Applicants are required to use the AAPI-online. At least two faculty members review the application, using our Application Rating Form. Applicants are notified by December 15 of their interview status.

Interview days include an orientation to CHA and to the internship program. Each applicant will likely have individual interviews with two faculty members. The Interview day runs approximately 5 hours, during which time applicants are provided with breakfast and lunch. Interviews are designed to explore applicants' experience and interest for assessment of fit, and to provide an opportunity for the applicants' questions. Interviews are deliberately not stress interviews.

Successful applicants are doctoral candidates in clinical, counseling, or school psychology. Applicants selected typically have 400+ clinical hours in practicum experience, have completed all required coursework and successfully defended their dissertation proposal.

Research Postdoctoral Fellows in Psychology Seeking Supplemental Clinical Hours

While the primary purpose of these research postdoctoral positions is to participate in research, Research Fellows may elect to apply to supplement their research activities with unpaid clinical work in the Department, especially for the purpose of obtaining state licensure. This application process includes an interview with the Director of Postdoctoral Training, and submission of materials (CV, doctoral transcript, letters of reference and clinical samples). The clinical experience resulting from this application will be crafted to meet the needs of both the Research Fellow and the Department of Psychiatry, and will involve appropriate clinical supervision and didactic seminars, including the postdoctoral professional development seminar.

Psychology Trainee Evaluation Procedures (All Training Programs)

Psychology interns, trainees and fellows will be formally evaluated twice during the training year. Comprehensive evaluations of interns, trainees and fellows will occur midyear and at the end of the training year. Interns, practicum trainees and fellows will also have several opportunities during the year to provide Training Directors, supervisors, and faculty with feedback.

The Division of Psychology uses a survey tool through CHA for completing most evaluations. The site permits authorized users to log on and complete quantitative and narrative evaluations. Every care is taken to protect the integrity of the process while also allowing interns, trainees, fellows, their supervisors, and instructors to receive easily accessible reports on the strengths of their work together and to identify areas for learning.

Only the Chief Psychologist and Training Directors may view the complete set of these evaluations. The interns, practicum trainees and fellows may view the evaluations completed by the supervisors, preceptors and seminar leaders who have evaluated their work. (Interns, practicum trainees and fellows do not have access to each other's evaluations) Supervisors, preceptors and seminar leaders may access only the evaluations their trainees have completed.

Templates of evaluation forms will be posted on the Psychology Division Team Page.

Evaluations Pertaining Specifically to Psychology Interns: The Clinical Portfolio

In September, the Chief Psychologist and Director of Internship Training will compile early feedback on the intern's adjustment to the internship and ability to engage a learning stance with preceptors, supervisors, seminar leaders, and training colleagues.

At mid-year, the Director of Internship Training will review evaluations from all supervisors with each intern. Learning objectives will be revised as necessary. Additional evaluations as required by the intern's doctoral program will also be completed by the Director of Internship Training. At the end of the year, the Director and Director of Internship Training will prepare a written evaluation for each intern that summarizes their work over the training year, including the intern's development, participation in the CHA community and his or her mastery of core competencies. The intern will have the option of signing this evaluation, which will be placed in the intern's file.

Interns' portfolios will also be rated by preceptors and instructors anonymously on the basis of direct observations of their clinical work, samples of audio-taped psychotherapy process, and of their presentations of psychological testing reports and feedback for program improvement purposes. These ratings, along with samples of de-identified intake and termination summaries, and supervisory ratings will comprise a "clinical portfolio," aggregating the intern's fulfillment of training goals and objectives.

Psychology Trainee Stipends & Health Benefits

Psychology Internship Stipend

Psychology interns receive a stipend of \$44,000 per year, with \$500 per year in educational benefits. Health and dental benefits are available at the level of full-time employees.

Postdoctoral Fellowship Stipend

Fellows receive a stipend of \$56,880, with \$1900 per year in educational benefits. Health and dental benefits are available at the level of full-time employees.

Practicum Trainees

Practicum placements are not funded and practicum students do not receive health or dental benefits.

Research Postdoctoral Fellowship Stipends

The unit sponsoring the research fellow and/or the terms of the granting agency out of which the fellow is funded determines the stipends and benefits for research fellows.

Sick Days and Medical Leave Guidelines (see also Pregnancy and Parental Leave Guidelines)

As a health facility, CHA asks its staff to safeguard our patients by observing prudent practices when a staff member is ill (e.g. observing hand hygiene, covering one's mouth when coughing, and staying away from work when one has a fever or otherwise may transmit an illness to others).

At the same time, trainees are expected to meet their training time obligations so that each trainee fulfills the terms of their clinical placement. Meeting training time obligations is required for us to certify you have met graduation criteria and for us to certify that your training time with us is sufficient for us to verify your hours for licensure.

Trainees do not have designated sick days. However, we appreciate that illness happens and we make allowances for that. Trainees who are absent from work for medical reasons

(illness, appointments, etc.) must contact their Team Leaders or Attendings, preceptors, and seminar leaders directly via email or phone. Ordinarily, the intern is not required to use time off for work missed for medical reasons. Exceptions to this policy are noted below:

1. If a trainee misses work for three consecutive work days, s/he will need to provide medical documentation from his/her care provider. If the trainee does not provide medical documentation, the entire period of time will be treated as time off and drawn from the trainee's time-off bank.

2. We recognize that occasionally trainees face the special challenge of an illness, surgery, or injury. If the trainee does not have enough time off in his or her bank to cover the additional time needed, the trainee may ask to extend his or her training time so that they complete their training time obligations. Such requests must be approved by the Training Director, the Chief Psychologist, and Service Leaders. Additionally, any psychology trainee may apply for medical leave of absence after the submission of appropriate documentation. Such leaves are without pay for up to 12 months. Requests must be directed to your Training Director and to the Chief Psychologist. In the event of a leave, Cambridge Health Human Resources must be notified so that an official leave letter can be sent, and arrangements can be made for health/dental contributions if any of the time is going to be unpaid.

3. Likewise, trainees who frequently miss work for medical reasons (illness, appointments, etc.) for periods of less than three consecutive working days may also be asked to provide medical documentation and/or to extend their training time, if their absences are judged to affect the trainee's ability to meet training time obligations.

4. Please note that psychology trainees who have been working consecutively at the Cambridge Health Alliance for one year (i.e. second year Fellows) have leave policies that are covered by the hospital's Family and Medical Leave Policy (available on Staff Net) which supersedes Psychology Division policies. Cambridge Health Human Resources must be notified of FMLA leaves so that an official leave letter can be sent, and arrangements can be made for health/dental contributions if any of the time is going to be unpaid.

Social Media Policies and Guidelines for all Psychology Trainees

Social media requires careful consideration with respect to professionalism. We have devised a Social Media Policies advisory for all trainees. We encourage you to discuss these policies and guidelines with your Training Directors. Please keep in mind that policy in this area is ever evolving.

The following policies apply (but are not limited) to FaceBook, LinkedIn, internet forums, chat rooms, blogs, YouTube, Google, wikis, text messaging, and all electronic media. Email-specific policies may be found on Staff Net.

Responsible Use—Sharing or posting patient, employee, or organizational information on any of these media is prohibited. Such information includes but is not limited to: protected health information (PHI), personal identifiable information, images of patients. However, protected patient information is not limited to demographic information. Content of sessions with patients—verbatim or paraphrasing—even without identifying information, is prohibited.

Maintaining Professional/Boundaries. Initiating contact with patient or families through these sites is not permitted. Accepting invitations to join social media sites of your patients is not recommended. In general, our recommendation to you is to decline offers or invitations from patients and families to view or participate in their online social network.

Use good judgment in thoughtfully weighing the potential for harm to patients and families in using the internet to communicate or to gather information about patients. This includes anticipating the possibility that one's patients and families, as well as other patients, families and hospital staff, may misinterpret social relationships outside the usual boundaries of care. In such cases, consulting with Training Directors and colleagues who are licensed psychologists in advance about how to minimize potential harm is recommended.

Harvard Medical School Authorship Guidelines

INTRODUCTION.

Authorship is an explicit way of assigning responsibility and giving credit for intellectual work. The two are linked. Authorship practices should be judged by how honestly they reflect actual contributions to the final product. Authorship is important to the reputation, academic promotion, and grant support of the individuals involved as well as to the strength and reputation of their institution.

Many institutions, including medical schools and peer-reviewed journals, have established standards for authorship. These standards are similar on basic issues but are changing over time, mainly to take into account the growing proportion of research that is done by teams whose members have highly specialized roles.

In practice, various inducements have fostered authorship practices that fall short of these standards. Junior investigators may believe that including senior colleagues as authors will

improve the credibility of their work and its chances of publication, whether or not those colleagues have made substantial intellectual contributions to the work. They may not want to offend their chiefs, who hold substantial power over their employment, research opportunities, and recommendations for jobs and promotion. Senior faculty might wish to be seen as productive researchers even though their other responsibilities prevent them from making direct contributions to their colleagues' work. They may have developed their views of authorship when senior investigators were listed as authors because of their logistic, financial, and administrative support alone.

Disputes sometimes arise about who should be listed as authors of an intellectual product and the order in which they should be listed. When disagreements over authorship arise, they can take a substantial toll on the good will, effectiveness, and reputation of the individuals involved and their academic community. Many such disagreements result from misunderstanding and failed communication among colleagues and might have been prevented by a clear, early understanding of standards for authorship that are shared by the academic community as a whole.

Discussions of authorship in academic medical centers usually concern published reports of original, scientific research. However, the same principles apply to all intellectual products: words or images; in paper or electronic media; whether published or prepared for local use; in scientific disciplines or the humanities; and whether intended for the dissemination of new discoveries and ideas, for published reviews of existing knowledge, or for educational programs.

The Faculty Council of Harvard Medical School has endorsed the following statement. Although authorship practices differ from one setting to another, and individual situations often require judgment, variation in practices should be within these basic guidelines.

AUTHORSHIP

1. Everyone who is listed as an author should have made a substantial, direct, intellectual contribution to the work. For example (in the case of a research report) they should have contributed to the conception, design, analysis and/or interpretation of data. Honorary or guest authorship is not acceptable. Acquisition of funding and provision of technical services, patients, or materials, while they may be essential to the work, are not in themselves sufficient contributions to justify authorship.
 2. Everyone who has made substantial intellectual contributions to the work should be an author. Everyone who has made other substantial contributions should be acknowledged.
- OMBUDS OFFICE**
3. When research is done by teams whose members are highly specialized, individual's contributions and responsibility may be limited to specific aspects of the work.
 4. All authors should participate in writing the manuscript by reviewing drafts and approving the final version.
 5. One author should take primary responsibility for the work as a whole even if he or she does not have an in-depth understanding of every part of the work.

6. This primary author should assure that all authors meet basic standards for authorship and should prepare a concise, written description of their contributions to the work, which has been approved by all authors. This record should remain with the sponsoring department.

ORDER OF AUTHORSHIP

Many different ways of determining order of authorship exist across disciplines, research groups, and countries. Examples of authorship policies include descending order of contribution, placing the person who took the lead in writing the manuscript or doing the research first and the most experienced contributor last, and alphabetical or random order. While the significance of a particular order may be understood in a given setting, order of authorship has no generally agreed upon meaning.

As a result, it is not possible to interpret from order of authorship the respective contributions of individual authors. Promotion committees, granting agencies, readers, and others who seek to understand how individual authors have contributed to the work should not read into order of authorship their own meaning, which may not be shared by the authors themselves.

1. The authors should decide the order of authorship together.
2. Authors should specify in their manuscript a description of the contributions of each author and how they have assigned the order in which they are listed so that readers can interpret their roles correctly.
3. The primary author should prepare a concise, written description of how order of authorship was decided.

IMPLEMENTATION

1. Research teams should discuss authorship issues frankly early in the course of their work together.
2. Disputes over authorship are best settled at the local level by the authors themselves or the laboratory chief. If local efforts fail, the Faculty of Medicine can assist in resolving grievances through its Ombuds Office.
3. Laboratories, departments, educational programs, and other organizations sponsoring scholarly work should post, and also include in their procedure manuals, both this statement and a description of their own customary ways of deciding who should be an author and the order in which they are listed. They should include authorship policies in their orientation of new members.
4. Authorship should be a component of the research ethics course that is required for all research fellows at Harvard Medical School.
5. These policies should be reviewed periodically because both scientific investigation and authorship practices are changing.

Supervision and Precepting in the Outpatient Department: Description of Roles and Reporting Relationships

Supervision and precepting relationships are core contexts in which clinical learning takes place at the Cambridge Health Alliance. You will be assigned a panel of supervisors and one preceptor for your outpatient caseload. The roles of preceptor and supervisor contain some overlap but are distinct in important ways.

Preceptor. This particular relationship may be new to many of you. Your preceptor is a psychologist who attends clinical team meetings along with you. The preceptor serves multiple functions: s/he works closely with you, the team leader, and the group of preceptors, to oversee your clinical work. Your preceptor serves as a role model and mentor on the outpatient team. The preceptor works with you and the team leader to build an appropriate caseload for you. S/he reviews every case with you each week, to keep abreast of treatment course, as well as clinical/risk formulation and management. S/he also reviews and signs your documentation. Toward this end, the preceptor, along with the team, holds primary responsibility for each case.

Supervisor. No doubt, you have had many experiences of supervision prior to training at CHA. The particulars of supervision in this setting, however, may be new to you. Many, though not all, clinical supervisors at CHA are engaged primarily in private practice, or clinical settings other than ours. They hold an academic appointment through Harvard Medical School, for which they provide 3 hours of supervision or teaching per week (known in our vernacular as “3-hour rule supervisors”). In this subset of supervisors, however, many have trained or been employed at CHA in the past. Thus, we expect our supervisors to have familiarity with our patient population and our setting.

You will present several of your cases to each supervisor (typically 3-4 patients per supervisor). It is important to distribute your caseload as evenly as possible to your panel of supervisors. It is also important to follow with only that supervisor the patients to whom you’ve assigned that supervisor. It is not appropriate—for clinical and risk management reasons—to alternate presentations of one case to different supervisors unless both supervisors are informed and give direct verbal consent to one another and to the preceptor.

At the onset of supervision, take time to learn about your supervisors’ clinical interests and experiences. This will assist you in thinking about which patients to present to whom. Of course, your supervisor can (and should!) weigh in on the decisions you make about which patient they will follow. Finally, talk with your supervisor about possible methods of case review: process notes, audiotape, and so on. Clinical supervision provides

an opportunity for in-depth learning about the micro-process of psychotherapy. We encourage you to make the fullest use possible of this opportunity.

Please note that in some sites the role of preceptor and supervisor are done by one clinician. In such instances, precepting hours are to be scheduled distinctly from supervisory hours in order to maintain clarity about roles and responsibilities.

Also, please note that supervision is expected to take place on site, in person. Phone supervision may occur in urgent matters, but should not substitute for regular, in vivo meetings.

Supervisory Assignments and Changes in Supervision

In this document, “trainee” refers to psychology practicum trainees, interns and fellows.

Trainees in psychology may request reassignment to another supervisor without prejudice. “Without prejudice,” in this context, means that neither the supervisor nor trainee will be assumed *a priori* to be deficient or in need of remediation.

Clinical supervision, like psychotherapy and other forms of intervention, requires an effective collaborative process. Difficulties, tensions and even impasses are to be expected as normative parameters of the work, in addition to the sense of pleasure and mastery that is also frequently part of the work we do together. When problems occur, the Division encourages supervisors and trainees to work collaboratively to address them. Some problems are straight-forward as when either supervisor or trainee is not living up to the expected tasks required of their role (e.g. meeting regularly). Other problems involve interpersonal strains or differences of opinion. Usually it makes sense to make more than one attempt to address such difficulties. It also requires both parties to be thoughtfully candid and to be willing to consider viewpoints neither may have had occasion to entertain before. Supervisors should avail themselves of consultation with the Training Directors in Psychology. Trainees ought to do the same and also use their preceptors as a resource to problem-solve ways to address supervisory issues with their supervisors. In most cases, we would anticipate that many problems can be sorted out and the supervision to continue.

We ask that supervisors be clear in their expectations about what supervision is to entail at the outset of supervision. We also expect that supervisors and supervisees will check in with one another throughout the training year to ascertain that their work is proceeding in ways that are beneficial to the trainee’s learning process. Both supervisors and trainees should anticipate that these conversations will include recognition of effective collaborations and areas for growth and development.

Mindful of the power disparities that exist between supervisors and supervisees, the Division supports changes in supervisory assignments if supervisory collaboration is not effective. Just as the patient-therapist match is an important predictor of psychotherapy outcome, the match between supervisor-supervisee may play a role in how and whether collaborative processes are established.

When an established supervision ends before the conclusion of the training year, the Training Directors will likely want to consult separately with both the trainee and the supervisor. This consultation may occur after the new supervisory assignment is made. It is hoped that these discussions would help each to understand the reasons behind the supervisory change. We also encourage supervisors and trainees who discontinue supervisory work together to have a follow-up conversation though we ask that supervisors permit trainees to initiate such a discussion (and to respect the trainee's privacy, if s/he opts not to have a follow-up conversation).

In circumstances where a supervisee does not feel that this approach provides an adequate mechanism for a particular problem with a supervisor, a trainee may speak with Dr. Beth Parsons who serves as our ombudsman for this purpose. This contact is confidential within the customary ethical parameters of the field. Dr. Parsons will describe the level of confidence she is able to offer should trainees contact her. Supervisors may also consult with Dr. Parsons if they wish some additional assistance.

Psychology Division Team Page

The Psychology Division will use a "Team Page" on the Cambridge Health Alliance as a platform to aggregate information and materials pertaining to the Psychology Division and Psychology Training. The team page lists relevant calendars, links, and resources. All seminar readings can be found on the team page, and trainees should use this link to find these resources.

Working in a Medical Health Care Setting

The Cambridge Health Alliance is an academic medical system affiliated with the Harvard Medical School. Although health care is optimally delivered through a bio-psycho-social approach and multidisciplinary teams, it is important to be mindful that the culture and setting within which we work is a medical one.

Working in a medical setting may be new for some psychology trainees, particularly those whose prior placements were in university counseling centers, private clinics, or schools. Although there is considerable variation across medical settings and the ways in which physicians are educated, keep in mind that those in training to become medical doctor work in a system of hierarchies and are socialized to make quick authoritative decisions. While

there is also a lot of variability in psychology training, many psychology trainees are taught to value reaching consensus and to appreciate ambiguity and uncertainty. Sometimes these cultures bump up against one another and conflict.

Take time to get to know your medical (and other colleagues), ask questions of residents about how they are being trained, and help them to understand psychology training. Hopefully, they will do the same. Physicians may not know the difference between an intern or a postdoctoral fellow or they may assume that psychology interns are akin to medical interns (i.e. with little clinical experience under their belts). Likewise, some of you may not yet know what the PRITE is or how the training for a DO differs from that of an MD. We encourage you to be curious rather than defensive when these matters arise.

Although residents and psychology trainees work side-by-side and may be learning comparable skills, for example, in how to conduct psychotherapy, there are also key differences between residents and psychology trainees. One of these is the fact that residents are licensed medical professionals *during* their training years whereas Psychology trainees usually become licensed only *after* training. Thus, residents do enjoy a different status within the hospital system by virtue of their licensure. They also have additional responsibilities as licensed professionals and they are compensated differently.

Remaining attentive to these issues may be helpful in the year ahead. Your Training Directors can help you to deal with any tensions that arise and to figure out creative ways to negotiate with colleagues from other disciplines. Training Directors will also help you to engage productively with the complex subsystems that comprise the Cambridge Health Alliance. As with all forms of intercultural dialogue, effective engagement is predicated on the values of respect, openness to learning, and alignment with the purpose of our shared work.

We believe that your gaining expertise in collaborative work and in systems is one means of learning to exercise effective leadership.

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