

Training Manual
Post Doctoral Residency in Rural Psychology

MCARPT

Minnesota Consortium for Advanced Rural Psychology Training

2010-2011

Tell me the landscape where you live, and I will tell you who you are.

--Jose Ortega y Gasset

If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.

--Antoine De Saint-Exupery

1900-1944

The American Psychological Association affirms that postdoctoral education and training remains an important part of the continuing professional development and credentialing process for professional psychologists. Postdoctoral education and training is a foundation for practice improvement, advanced competence, and inter-jurisdictional mobility.

--Policy Statement

American Psychological Association

February 2006

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I. Introduction to Rural Psychology Needs and Training Issues

The unique cultural of rural America presents challenges to the effective delivery of healthcare in frontier areas and its impact on delivery and maintenance of mental health services to rural Americans. Rural Americans are disproportionately underserved by mental health services of all disciplines. Part of this challenge is that psychologists and other mental health professionals are inadequately prepared to practice in rural communities across the country. Rural psychologists, by necessity, must be generalists and understand the unique ethical and professional challenges of practicing in small communities where the day to day delivery of mental health services may be vastly different than in urban settings. As most graduate schools of professional psychology have a distinctly urban bias, many graduates are ill prepared to function as independent rural mental health practitioners in small towns and frontier communities. This leads to a cycle of recruitment, retention, and attrition activity for rural communities which extracts an enormous price both in the economic losses, and in the fracturing of services that rural communities desperately need.

Rural communities, including those in Northwestern Minnesota are underserved with regard to psychological services. The prevalence of mental illness in rural communities meets or exceeds that of urban communities. Rural communities have inordinately difficult tasks in recruiting and retaining mental health professionals due to several factors:

- ✓ Lack of graduate or post-graduate training in the unique aspects of rural practice.
- ✓ Professional isolation, lack of a cohesive mental health “community” in which to practice, and heightened stress of providing services geographically disconnected from other providers.
- ✓ Lack of community resources to retain mental health providers
- ✓ Lack of familiarity with the complex intertwined system of mental health delivery in rural communities, which interfaces professional, paraprofessional, governmental, medical and social service systems.
- ✓ Need for generalist skills and orientation in a world of specialization. Psychologists must take on multiple roles in communities where healthcare providers are in great demand. Thus, many psychologists are forced to provide services that would normally fall outside their “comfort zone” or scope of practice.

A “snapshot” of mental health concerns in rural communities highlights the problem:

1. Over the past 20 years, rural suicide rates for adolescents and adults have surpassed urban suicide rates in large part due to dispersed populations, large geographic areas, and shortages of trained professionals and resources.(Fingerhut & Gunderson, 1995; National Center for Health Statistics, 1995, Marshfield Clinic, 2000).
2. Rural residents are more likely to be victims of violence than their urban counterparts (SAMHSA, 1995).

3. Alcohol and drug use is higher in rural residents than in urban or suburban residents, especially among rural youth (Columbia University, 2000).
4. Depression threatens the health of rural residents (APA Public Policy Office, n.d.).
5. An estimated 2/3 of rural residents with mental illness receive no care at all. Less than 10% of the 2200 rural hospitals across the nation offer mental health services. Further, 75% of federally designated Mental Health Shortage Areas are rural (APA Public Policy Office). ***The entire catchment area for the MCARPT program is federally designated as a mental health shortage area.***
6. Lack of transportation is a serious obstacle to obtaining and maintaining mental health services in rural areas (Bierman, 1997).
7. Rural areas lack all forms of healthcare providers. But, the shortage of mental health professionals outstrips that for medical or dental health. In the 3075 counties in the United States, 55% (all rural) have no practicing psychologist, psychiatrist, or social worker (Bureau of Primary Health Care, 1999).
8. Most rural residents face “triple jeopardy”: They are poor, uninsured (20% of all rural residents have no health insurance), and live in geographically isolated areas.
9. The Midwest farm crisis of the 1980s has had significant and lasting effects on the mental health of rural Americans (Conger, 2002).
10. Although by some definitions, up to 90% of the country’s land area is rural, less than 25% of Americans live in those areas and are subjected to high unemployment, shortage of services, and lack of community infrastructure.

Professional and governmental leaders have addressed the need for specialized training and attention to the growing crisis in rural communities:

- *“At the same time, much more needs to be done, particularly with regard to problems associated with insufficient numbers of qualified mental health professionals in rural and frontier areas. The federal government has been the major force responsible for molding health professionals’ education, partly through the sponsorship of innovative training practices and preparation of professionals for underserved areas. At the same time, mental health and substance abuse training have received considerably less support as compared to traditional medical specialties.”*

Dunivin, D. (1994). Health professions education: The shaping of a discipline through federal funding. *American Psychologist*, 49, 868-878.

- *“Rural professionals often work in relative isolation and without many of the professional and personal amenities enjoyed in urban settings. Rural practitioners often lack professional peers to consult with on difficult cases and to share evening and weekend emergency coverage; frequently find appropriate continuing education programs inconvenient, inaccessible, or unaffordable; and often feel personally cut off from the cultural, educational, and recreational activities they grew accustomed to during their more urban and university based training years.”*

Wagenfeld, M., Goldsmith, H., Stiles, D., Longest, J., & Manderscheid, R. (1988). Inpatient mental health services in non-metropolitan counties. *Journal of Rural Community Psychology*, 9, 13-18.

- *“The differences between rural and urban communities present another source of diversity in mental health services. People in rural America encounter numerous barriers to the receipt of effective services. Some barriers are geographic...and some barriers are ‘cultural’ insofar as rural America reflects a range of cultures and lifestyles that are distinct from urban life. Urban culture and its approach to delivering mental health services dominate mental health services.”*

Beeson, P., Critain, C., Howell, M., Kirwan, D., & Sawyer, D. (1998). Rural mental health at the millennium. In Mandersheid, R. & Henderson, M. (Eds.). *Mental Health United States, 1998*. (DHHS Publication No. SMA 99-3285, 82-98). Washington, D.C: US Government Printing Office.

- *“The notion that rural Americans enjoy a healthier lifestyle and a lower incidence of mental disease is an unfortunate misconception.”*

National Advisory Committee on Rural Health and Human Services

In 1997, the **United States Department of Health and Human Services** issued a report produced by the **Ad Hoc Rural Mental Health Provider Work Group** which included 5 recommendations aimed at addressing the mental health provider shortage in rural America:

1. **Recommendation #1:** *The mental health professions should actively encourage innovative training strategies (both in terms of didactic and experiential training) that are explicitly targeted at expanding the competencies required to practice effectively in rural settings.*
2. **Recommendation #2:** *Training programs should make concerted efforts to recruit qualified applicants from rural areas who are more likely to practice in rural regions after graduation.*
3. **Recommendation #3:** *Interdisciplinary collaboration can accomplish several goals with regard to enhancing the supply and effectiveness of mental health providers in rural areas and improving consumer access to these providers. Because interdisciplinary training makes such collaboration more likely to occur, the Work Group recommends several strategies to increase interdisciplinary training and service delivery opportunities.*
4. **Recommendation #3A:** *Funding should be provided to increase the number of rural interdisciplinary practices, internships, and residency placements currently available.*
5. **Recommendation #4:** *It is critically important to fund training of mental health service providers. Federal and state funds for training activities should be made available to both: (a) disciplinary based efforts to train individuals for rural mental health provider roles; and (b) efforts that view interdisciplinary training and collaboration as critical to providing services to rural and other at-risk populations.*

In examining the state of mental health for **Minnesotans** and access to mental health services in rural communities, the data is equally alarming:

1. Over 950,000 Minnesotans, or approximately 19% of the state's population, has a diagnosable mental health condition (Minnesota Mental Health Association).
2. The Minnesota Department of Health, Office of Family Health, estimates that nearly 175,000 Minnesotans have a serious mental illness in any given year.
3. The Minnesota Department of Health acknowledges that there is a greater chance that mental health services may be limited or non-existent in rural settings.
4. The Minnesota Board of Psychology reports 3288 licensed psychologists practicing in Minnesota as of 2003. This is approximately 66.8 psychologists per 100,000 population. This is well above the national average of 31.2 per 100,000 population, but the distribution is uneven. *Non-metro counties in greater Minnesota report 0-13 psychologists per 100,000 citizens compared to 123.7 per 100,000 in Hennepin County.*
5. In 2000, 67% of rural Minnesota hospitals reported that they had no access to mental health services, either on staff or via provision by contract.
6. A 2005 report by the Minnesota Department of Health shows that fatal suicides are significantly more likely in rural Minnesota (11.6 per 100,000 population) than in urban parts of the state (8.1 per 100,000 population).

→ MCARPT is proud to have been named a **“promising practice”** by the Minnesota Department of Health, Office of Rural Health and Primary Care, in MDH's 2005 report on Mental Health and Primary Care. That report is available at <http://www.health.state.mn.us/divs/chs/mentalhealth.pdf>

II. *History and Mission of MCARPT*

MCARPT is an alliance of mental health professionals, mental health agencies, social service providers, medical health facilities and county and tribal government along with allied agencies located in rural Becker, Mahanomen, and Ottertail counties along with the White Earth Reservation. The primary goal of MCARPT is to recruit and prepare doctoral level psychology graduates to assume positions of healthcare leadership in rural and frontier communities. In accomplishing this goal, MCARPT will address the significant shortage of doctorally trained psychological practitioners across our rural communities. MCARPT was conceived in 2002 as a means of addressing the ongoing and serious shortage of doctorally trained psychologists in rural Minnesota. In late 2002, MCARPT wrote and received a Rural Flex Grant from the Minnesota Department of Health (Office of Rural Health and Primary Care) to develop a 4000 hour curriculum in rural psychology (later revised to a 2000 hour, one year curriculum). The curriculum writing was completed in June 2003. In July of 2003, the curriculum, core competencies, and rotation outlines were reviewed by Dr. Kathy Harowski, a psychologist with the VA Hospital in Minneapolis and a member of the Council on Rural Health of the American Psychological Association. Dr. Harowski's final evaluation noted:

“The core competencies, developed by the consortium members, represent the spectrum of clinical service needs of the rural population. Indeed, several of the competencies focus on the most significant demographic growth areas for rural Americans...The work put into the core competencies and the descriptions of the clinical

proficiencies is thorough and the behavioral objectives are clearly defined and can be measured in terms of completion/outcome...”

When the beginning vision of MCARPT was developing, one of the first functions was to convene a meeting of area providers and potential rotation site hosts. From this meeting it was very clear that all of the providers saw the value of and need for the project. Each site made a commitment to be a part of the planning work that needed to be done over the course of the year as well as to provide insight, resources, and writing expertise into the development of the ten core competency areas and the curriculum that would evolve from the partnership. When applying for the original Rural Flex Grant through the Minnesota Department of Health (MDH), the local family service collaborative, Becker County Children’s Initiative (BCCI) enthusiastically served as the fiscal agent for the program. In 2005 MCARPT became recognized as a non-profit 501(c)(3) organization. MCARPT moved to contract with MeritCare Health System (**Now Sanford Health**) in 2006 to be the “employer of record” in order to capitalize on MeritCare’s strong history of providing quality healthcare services to the residents of North Dakota and Northwestern Minnesota. Further, MeritCare’s infrastructure of 7000 employees made them the natural partners for MCARPT’s training program. MCARPT trainees will be classified as “temporary employees” of the Sanford Health Medical Group but will be managed, directed, and supervised by MCARPT staff.

III. *Program Philosophy*

The MCARPT program subscribes to a practitioner-scientist training model. It is our belief that professional psychologists are uniquely trained to assume clinical, teaching and leadership roles in rural communities. We value the combination of scholarship, academics, familiarity with research in psychology, and the ability of these to directly inform applied practice. MCARPT envisions the one year postdoctoral training experience as the minimum necessary preparation for trainees to assume positions of psychology leadership in rural areas. As rural psychologists are by nature and by need, generalists, the MCARPT program strives to provide supervised training in a diverse spectrum of ages, patient populations, patient problems, psychopathology, and treatment modalities. Further, MCARPT emphasizes the understanding and appreciation of the unique needs, culture, and customs of rural America.

Satisfactory completion of the MCARPT program meets the supervised post-degree requirements for licensure as a “licensed psychologist” in the state of Minnesota by the Board of Psychology. Trainees should verify that MCARPT’s program also meets the standards for licensure preparation in other states in which they may intend to reside and practice. The program also strives to comply with the Standards of the American Psychological Association (APA) for Accreditation of Psychology Post-Doctoral Residencies (effective July 2005). Consistent with APA standards for post-doctoral training, MCARPT strongly encourages that trainees participate in state, regional, national, and international professional and scientific organizations. MCARPT strongly recommends that trainees join and participate in the Minnesota Psychological Association (MPA) and the rural and greater Minnesota division of MPA.

In keeping with standards of residency training of the American Psychological Association and recognizing the value of diversity in the understanding of psychological principles and practices, MCARPT encourages trainees to understand and integrate the importance of culture and diversity in all training and didactic experiences. Diversity includes, but is not limited to:

- ❖ Age
- ❖ Physical disability
- ❖ Ethnicity
- ❖ Gender
- ❖ Gender identity
- ❖ Language
- ❖ National origin
- ❖ Race
- ❖ Religion
- ❖ Culture
- ❖ Sexual orientation
- ❖ Socioeconomic status
- ❖ Health status

IV. Profiles of MCARPT Communities

The MCARPT programs serve a tri-county area of Northwestern Minnesota whose catchment area also includes the White Earth Reservation. All counties involved in the program as well as the White Earth Reservation are federally designated mental health shortage areas as are all surrounding counties. Further, examination of the social and economic conditions of MCARPT communities helps to clarify the difficulties that residents of the area typically encounter. Issues of poverty, unemployment, inadequate insurance coverage, lack of public transportation, aging, teen pregnancy, divorce, violence, and other social stressors are a part of the landscape of rural Minnesota.

Table 1: Demographics of MCARPT training area (Data from 2007)

Area	Population	Square Miles	Unemployment
Becker County	30,000	1,311	7.2%
Mahnomen County	5,190	556	8.1%
Ottertail County	57,159	1,980	6.9%
State of Minnesota	4,919,479	79,617	5.1%

Timely and consistent assistance from mental health providers is crucial in assisting our families and communities deal with these stressors. Table 2 shows the depth of social challenges in our catchment area.

Table 2: Poverty and social assistance programming in MCARPT catchment area

Area	Children in Poverty	Children Receiving Food Support	Children Receiving Free/Reduced Lunch	Teen Mothers
State of Minnesota	10%	10%	26.5%	15%
Becker County	17%	16%	36%	22%
Mahnomen County	22%	27%	64%	48%
OtterTail County	13%	7%	29%	10%

The White Earth Indian Reservation is an important partner in the MCARPT network. It is important to note that the Reservation boundaries include three counties: a portion of Becker and Clearwater counties and all of Mahnomen county. Mahnomen County is wholly within the boundaries of the White Earth Reservation. Table 3 illustrates the economic challenges of the MCARPT communities and its implications for subsequent mental health concerns.

Table 3: Income and poverty levels in MCARPT catchment area

Area	Per Capita Income	Median Family Income	% of families below poverty level	% of families with children under 18 years old below poverty level	% of families with children under 5 years old below poverty level	% of families with female head of house below poverty level
State of MN	\$23,198	\$56,874	5.1%	7.6%	10.0%	19.3%
Becker County	\$17,085	\$41,807	8.5%	14.0%	18.0%	34.0%
OtterTail County	\$18,014	\$42,740	6.7%	9.7%	14.3%	27.0%
White Earth	\$12,786	\$33,144	15.9%	22.9%	28.2%	35.9%
Mahnom County	\$13,438	\$35,500	11.8%	19.2%	23.2%	32.8%

MCARPT believes that successful implementation of the post-doctoral training program will benefit host communities in several measurable ways:

- ✓ **Increased access** to mental health clinicians, trained specifically to recognize and respond to the unique social and cultural needs of rural clientele.

- ✓ **Reduction in waiting time** for access to doctorally trained mental health practitioners.
- ✓ **Decreased transience** of rural providers and increased stability of professional psychological services.
- ✓ **Bridging together** of service providers in a tri-county area allowing more integrated and seamless delivery of healthcare services. MCARPT will bind together numerous diverse agencies to increase communication and coordination of healthcare by virtue of its interdisciplinary and interagency training approach.
- ✓ **Destigmatization** of accessing mental health services as the 11 participating agencies promote mental health awareness, training, education, and access as an integral part of their community mission.
- ✓ **Significant cost offset effects** associated with increased access to mental health services.

V. *MCARPT Core Competencies*

The MCARPT program is based on the acquisition and mastery of 11 core competencies that MCARPT believes are necessary to function as a psychologist clinician, consultant, teacher and community leader. The selection and design of the rotational sites and curriculum is heavily dependent on their relationship to the core competencies of rural practice. All clinical activities of the fellowship are based on their relationship to these competencies and it is these values that drive the continuous quality assurance and ongoing evolution of the training program. Individual clinical tracks will emphasize some competencies over others in keeping with the particular specialty track (primary care vs. clinical community)

1. Outpatient mental health practice in both traditional and primary care settings.
2. Psychological practice and service delivery in primary care hospitals.
3. Innovative and non-traditional delivery of mental health services: in home treatment and day treatment programs.
4. Outpatient substance abuse assessment, diagnosis, education and treatment.
5. Domestic violence assessment, intervention, education, and treatment.
6. Delivery of psychological and consultation services to governmental agencies: County Social Services, Law Enforcement, Tribal Government, and the Courts.
7. Delivery of psychological services (assessment, diagnosis, consultation, education, and treatment) to local school districts and educational institutions.
8. Delivery of geropsychological services to nursing homes, supervised residential facilities and extended care facilities.
9. Multicultural competency, sensitivity to diversity, and recognition of the role of background, ethnicity, and environment in the successful delivery of effective psychological services.
10. Research, community leadership, and program evaluation.
11. Awareness, understanding, and sensitivity to unique ethical, professional, and personal challenges of rural practice.

VI. *Selection of Psychology Residents*

The MCARPT post-doctoral psychology fellowship program accepts applications in the Spring for the academic cycle beginning in October of each year. Completed applications are due by May 1st each year. Applications are encouraged from students who possess, or will possess by the beginning of the training year (required), a Ph.D/Psy.D. in clinical or counseling psychology, from universities or professional schools accredited by the American Psychological Association (APA) or the Canadian Psychological Association (CPA). Applicants must submit documentation directly from their university registrar showing award of the doctoral degree prior to beginning the MCARPT training program. In some cases where the end of the pre-doctoral internship is too close to the beginning of the residency training to permit such documentation, MCARPT will consider a letter from the applicant's dissertation chair/major professor, on university stationery, supporting the completion of all degree requirements, as interim evidence of degree completion. Residents must still submit official documentation from the registrar as soon as available. Successful applicants will have completed a 12-month/2000 hour pre-doctoral internship in sites that meet the criteria for listing by the APA or the Association of Psychology Postdoctoral and Internship Centers (APPIC). Applicants who have completed internships that are accredited by the APA or CPA are highly desirable but not required. Depending on funding and availability of consortium sites, MCARPT accepts two psychology residents each training year. Of critical importance to the MCARPT program is that applicants possess a substantial and demonstrated interest in rural practice and commitment to future professional service to rural communities. Outstanding applicants whose educational preparation does not meet the above criteria may be considered for placement in the MCARPT program as determined by the clinical director and board of directors. Completed applications will consist of:

- ❑ Copy of all graduate level transcripts
- ❑ Letter of interest including experience in rural communities
- ❑ Copy of most current curriculum vitae
- ❑ 3 letters of recommendation from professionals who can evaluate potential for success in a post-doctoral training consortium. At least one letter should be from a psychologist who has supervised the applicant in his/her training.
- ❑ Copy of any professional licenses and/or certifications
- ❑ One sample of applicant's professional writing (diagnostic evaluation or psychological test report with all identifying information recused).

Application materials should be mailed to:

MCARPT
C/O Jeffrey Leichter Ph.D., L.P.
Sanford Health System
1219 Washington Ave.
Detroit Lakes, MN 56501

When applications are completed, initial screening is made by the clinical director of the program or his/her designees. Viable candidates are invited to interview in Minnesota.. MCARPT will pay normal and customary expenses for the interviewee's costs associated

directly with the interview. Costs for a spouse, partner, or significant other who may choose to accompany the applicant are not covered and are the sole responsibility of the interviewee. Following completion of interviews, offers of placement are made based on recommendation by the clinical director to the board of directors. Selected residents are required to pass law enforcement background screens, drug screening, and health certification screening as required by the new employee orientation of Sanford Health System. Additionally, residents will be expected to successfully pass any and all provisions of the orientation requirements and mandatory education for new healthcare professionals within the Sanford system. Other MCARPT sites may have additional orientation activities that the resident is required to pass.

VII. *Employer of Record*

MCARPT has contracted with Sanford Health System to be the “employer of record” for the MCARPT fellowship program. While maintaining independence in design, implementation, and revision of the professional training program, MCARPT recognizes the value in having a larger corporate infrastructure act as the administrator of salary and benefits. As such, psychology residents selected by MCARPT will be classified as “temporary” Sanford employees. Sanford will manage stipend, benefits, and administrative oversight. The MCARPT board and clinical director will maintain complete control of the content of the program, rotational sites, and training competencies.

VIII. *Board of Directors*

MCARPT programs, curriculum, and professional oversight are organizationally managed by a board of directors and executive director. For 2010-11, this includes:

1. **Jeffrey Leichter Ph.D.,L.P.:** Licensed psychologist with Sanford Health System, Detroit Lakes clinic. (Clinical director)
2. **Don Janes M.A., L.P.:** Director of Children’s Mental Health Programs, Becker County Human Services, Detroit Lakes, Minnesota (Secretary/treasurer)
3. **Monte Fox:** Director, White Earth Health Services (Board member)
4. **Donald Preussler Ph.D., L.P.:** Licensed psychologist with Sanford Health System, Detroit Lakes and Perham, MN. (Assistant Clinical Director and Board member)
5. **Sue Sailer LSW:** Licensed social worker and Director of Social Services, Perham Memorial Hospital and Home, Perham, MN (Founding board member)
6. **Cyndi Anderson:** Director, Mosaic Consulting, Detroit Lakes, MN. (Executive Director)

IX. *Training Schedule*

The following represents the current MCARPT consortium members and rotational designations. This may change from year to year based on availability of supervisors, site availability, and funding changes. Not all residents will be placed at all sites. This will be determined primarily by emphasis track, availability of supervisory resources, and

trainee interest and expertise. Efforts will be made to accommodate resident preferences based on individual interests. On average, residents can expect to spend approximately 60% of their time in direct and indirect clinical service provision. An additional 2-4 hours/week of time is spent in supervision and case conference.

MeritCare Clinic

Outpatient mental health practice in traditional and primary care settings During these rotations, residents will be exposed to the role of the psychologist in primary care ambulatory rural medical clinics. Emphasis will be on collaboration and consultation with primary care medical doctors, medical specialists, and other healthcare professionals. Activities will include individual psychotherapy, diagnostic assessment, and consultation of patients normally encountered in a rural medical facility.

Clinical Supervisors: *Jeff Leichter Ph.D., L.P.; Gail Pickett, Ph.D., L.P.; Donald Preussler Ph.D., L.P., Brian Gatheridge Ph.D., L.P. (Depending on site)*

Detroit Lakes ISD #22 / Pine Point School/Waubun School: Delivery of psychology services to local school district: This rotation will expose the psychology resident to mental health issues normally encountered in rural school districts, including the White Earth Reservation, and will provide opportunities for interaction and consultation with teachers, parents, and school personnel. The rural psychologist needs to be proficient in providing necessary assessment and diagnosis as well as appropriate therapy interventions for common student mental health issues. This may include, but is not limited, to the categories of mood disorders, anxiety disorders, adjustment disorders, behavioral disorders, learning disabilities, classroom performance issues, and parent-child conflict areas. Rotational experiences may include supervised diagnostic assessments of district students, training in use of school related psychometric instruments, individual and group therapy with selected students, collaboration with educators and parents, co-facilitation of student therapy groups, and inservice training of school staff.

Clinical Supervisor: *Sarah Jensen Fritz, M.A., L.P.*
Brian Gatheridge Ph.D., L.P.
James Torkildson Ed. D., L.P.

Lakes Crisis & Resource Center Domestic violence assessment, intervention, education and treatment: This rotation provides the resident an opportunity for understanding of the current practice concepts of rural domestic violence, domestic crimes, spousal abuse, sibling abuse, and the continuum of conflict in rural families and relationships. Rural communities experience violence in both traditional and non-traditional families at a rate that exceeds that of urban communities. Psychologists must be aware of current literature and practice standards in the area of battering and violence in order to adequately serve the community at large. This rotation will also include exposure to conceptual understanding of power and control in the cycle of violence, the relationship of rural culture (agricultural issues, spiritual/religious issues, cultural diversity) to domestic violence, and an understanding of forensic issues pertaining to domestic violence including awareness of the legal processes pertaining to restraining

orders, witnessing children, court room policies, and interagency cooperation with police and attorneys. Rotational experiences may include working on call with domestic abuse advocates, educating staff and volunteers about mental health issues pertaining to violence and abuse, provide short term psychological services to selected clients seeking services for difficulties related to witnessing or experiencing violence, designing and/or co-facilitating support groups for adults and children who are affected by violence, participate in providing mental health services to adults and children participating in the Positive Connections visitation center.

Clinical Supervisor: *Jeffrey Leichter Ph.D., L.P.*

White Earth Tribal Mental Health & IHS Public Health Clinic, White Earth Reservation

Multicultural competency, sensitivity to diversity and recognition of the role of background, ethnicity, and environment in the successful delivery of effective psychological services. This rotation provides the resident the opportunity to recognize the role of culture and world view and how they affect clinical practice, expectations and attitudes that mental health professionals and American Indian clients (and other ethnic minorities) have toward one another. This rotation will permit the psychology resident to begin to develop an understanding of the American Indian client, specifically Anishinaabe culture, ethnicity, spirituality and historical trauma in the delivery to and reception of mental health services, by the American Indian client, in a rural setting. Rural psychologists must be aware of the variables of acculturation, communication, interpretation of behaviors, beliefs, intergenerational and historical perspectives, and evaluation of clients from ethnically diverse cultures in order to effectively serve rural communities. This also includes becoming sensitive to the culture of poverty, both on and off the reservation, and its impact on provision of effective psychological services. Rotational experiences with these two partners will include exposure to both tribal based mental health services, as well as participation in more traditional Western mental health concepts via the federal Indian Health Service clinic. Activities may include providing mental health diagnostic and treatment services to ambulatory Indian clients through the Indian Health Service (IHS), participation in alternative mental health treatment delivery approaches through local tribal agencies (in home and school based psychological services) , consultation, collaboration, and education to both IHS and tribal professional and para-professional staff, direct instruction from tribal historian, attendance at tribal cultural and governmental events, and exposure to the integration of spiritual and psychological concepts in the understanding of American Indian clients.

Clinical supervisor: *Darryl Zitzow Ph.D., L.P.*

Troy Carlson M.A., L.P.

Lakeland Mental Health Center

Community Mental Health Services. In rural communities, innovative and creative delivery service models are utilized to compensate and overcome shortages of treatment settings and qualified mental health providers. Due to the disproportionate level of poverty in rural and frontier communities, the concept of day treatment and other group formats are used as a low cost alternative to inpatient mental health care, usually not available in rural communities. The goal of day treatment for rural citizens is to reduce

patients' symptoms and enhance their overall functioning and quality of life. This rotation offers the resident the opportunity to participate in the execution of a variety of clinical programming for both children and adults, perform diagnostic evaluations of program participants, collaborate with mental health center staff in client interviews and record reviews, and understand the Adult Rehabilitative Mental Health Services (ARMHS) program in relation to rural service delivery. Further, residents will have exposure to the Community Support Program (CSP) which serves rural citizens with serious and persistent mental illness (SPMI) and understand the role of such services in the context of rural mental health programming. Significant opportunities will be provided for individual assessment and therapy cases.

Clinical Supervisor: *Gary Bowman Ph.D., L.P.*

Perham Memorial Hospital and Home/Oak Crossing: Service delivery in primary care hospital and delivery of geropsychological services to nursing homes and extended care facilities. Rural psychologists, as community healthcare leaders, are frequently consulted to provide psychological services to small hospitals and nursing homes. The professional psychologist practicing in a rural community must understand the central role of the local hospital in the fabric and history of the community. It is a resource which touches the lives of rural citizens from birth through the lifespan to death. The practice and privilege of rural hospital based psychological services can be extremely confusing and fraught with cultural rules and regulations that are unfamiliar to the newly graduated psychology resident. In rural settings, the need for cross-discipline understanding and cooperation is particularly accentuated given the paucity of healthcare providers. As primary care physicians are the central healthcare gatekeeper in rural hospitals and clinics, this training experience will emphasize effective communication and collaboration and development of alliances with primary care physicians in assessment and treatment of both traditional mental health disorders as well as being contributors to the management of healthcare problems encountered in hospitals and nursing homes. As part of this experience, residents will begin to understand the theory, practice, language, and culture of primary care medicine and compare and contrast cultural differences and similarities of rural psychology and rural medicine and identify barriers and catalysts to successful collaboration. Residents will have the opportunity to complete psychological assessments of patients hospitalized in rural community medical facilities and extended care facilities to include evaluations of both traditional psychological disorders and concerns as well as psychosocial, family, and cultural issues which impact the course of hospitalization, discharge, and long term planning

Clinical Supervisor: *Sue Sailer LSW*

Director of Social Services, Perham Hospital and Home

Gail Pickett, Ph.D., L.P.

Jon Aligada Psy.D., L.P.

Becker County Human Services and Becker County Public Health and Juvenile Probation Department Delivery of psychological services to governmental agencies (County social services, law enforcement and the courts). Rural psychologists are charged with developing and maintaining working relationships with a number of service

agencies, community representatives, and governmental offices. Successful collaboration with other professionals is one of the keys of effective utilization of limited healthcare resources. These 2 rotations will offer the resident the opportunity to develop a working knowledge of the roles, responsibilities, and realities of various human service agencies and care providers in the consortium's main catchment area of Becker County. Activities will include participation in interagency supervisory and staffing meetings with area mental health providers through the Becker County Social Service office in Detroit Lakes and the Public Health Department which is currently subsumed under Social services administratively. Under supervision, residents will participate in assessment, evaluation and brief counseling, both on site and off site, of clients served by these agencies. Additionally, residents will be exposed to twice monthly staffing of clients jointly served by county social service case managers, White Earth Tribal Mental Health, Lakeland Mental Health Center, Stellher Human Services, and others. These meetings will give the resident an overview of both successful collaboration between agencies and an understanding of obstacles to interagency cooperation and facilitation of service delivery. Also, the resident may participate as part of a multidisciplinary child/adolescent treatment evaluation/treatment team for at-risk youth and/or working collaboratively with public health nurses serving clients with chronic medical conditions.

Clinical Supervisor: *Don Janes M.S., L.P.*

Director, Children's Mental Health Program
Becker County Human Services

DOVE (Down on Violence Everyday: Domestic violence assessment, intervention, education and treatment): This rotation provides the resident an opportunity for understanding of the current practice concepts of rural domestic violence, domestic crimes, spousal abuse, sibling abuse, and the continuum of conflict in rural families and relationships with particular attention to the American Indian community. The DOVE program is located on the White Earth Reservation and serves enrolled members through a combination of professional, paraprofessional, and culturally based interventions.

Clinical Supervisor: *Darryl Zitzow Ph.D., L.P.*

Individual and Group Supervision

Psychology residents will have regularly scheduled individual and group supervision, a minimum of two hours per week with the program director and/or another licensed psychologist/mental health professional as designated by the program director. This will provide the resident the opportunity for discussion of assigned cases and duties, provide a forum for discussion of professional development, and clarify expectations and experiences. Residents are expected to be prepared to present individual client concerns as they arise. One and a half hours/week of group supervision or didactic seminar will be regularly scheduled to provide opportunities for ongoing scholarly education, experience in case presentation, and peer review and support. Additional individual supervision and case conference will be scheduled by site supervisors at individual agencies. Psychology residents have historically averaged approximately 4 hours/week of combined individual and group supervision. From time to time, MCARPT will invite outside scholars to present topics of interest to psychologists, residents, and other interested health care professionals.

X. *Professional Title*

Trainees in the MCARPT program are likely to encounter clients and both professionals and non-professionals alike who are unfamiliar with ethics and standards of professional behavior in the psychology profession. As such, it is incumbent upon the trainee to clarify to all program consumers and stakeholders the appropriate title of their role within the MCARPT program. The term “psychologist” is a regulated title in Minnesota as determined by the Minnesota Board of Psychology Practice Act, section 148.907 (*Licensed Psychologist*) and 148.96 (*Presentation to the Public*). Only those persons licensed by the Board of Psychology may represent themselves as a *psychologist*. The American Psychological Association’s (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 2002), section 5.01, *Avoidance of False or Deceptive Statements*, similarly prohibits misrepresentation of credentials or education. Therefore, trainees in the MCARPT program who are not licensees of the Minnesota Board of Psychology will be designated ***psychology resident*** during the course of their fellowship with MCARPT. Those trainees who successfully are awarded a license to practice independently as a psychologist in the state of Minnesota by virtue of being assigned a license number AND who are still trainees in the completion of the MCARPT program requirements may use the title “psychologist” in their professional activities. Trainees who knowingly use the title “psychologist” in the absence of being awarded such distinction or those trainees who attempt to mislead others as to skills, training, or preparation for the practice of psychology are in violation of APA ethical guidelines, MCARPT training standards, statutes of the Minnesota Board of Psychology, as well as Minnesota law and will result in disciplinary action by the MCARPT program. Trainees will be required to accurately convey to the public all relevant information concerning their training and educational background, the limits of their training, the names and credentials of their faculty supervisor(s), and the right of a client to request a different clinician at any time. All documentation and clinical reports that trainees will sign in their role as psychologists-in-training will be: *Clinician’s name, highest degree awarded, any license or certification that the trainee holds in a mental health or related discipline, and the words “psychology resident.”* **Any** progress notes, letters, written assessments, reports, or written communications pertaining to patient care must be reviewed, approved and co-signed by the designated psychology site supervisor or clinical director of MCARPT.

XI. **Faculty Profiles**

Jeffrey Leichter Ph.D., L.P., Clinical Director

Dr. Leichter was born and raised in Long Beach, California. He graduated from the University of California, Irvine, with a bachelor’s degree in biological sciences in 1982. He enrolled in the graduate program at the California School of Professional Psychology (now Alliant University) in Los Angeles and obtained a master’s degree in 1985 and a Ph.D. in 1987 in clinical psychology. From 1987-1989 he was a postdoctoral fellow and instructor in primary care health psychology at St. Joseph’s Hospital/Michigan State

University State Department of Family Medicine. From 1989-1990 he was a staff psychologist and the director of behavioral medicine at National Rehabilitation Hospital in Washington, D.C. In 1990 he joined the staff of MeritCare Clinic in Detroit Lakes, Minnesota as a clinical psychologist and served in that capacity until 2000. From 2000-2001 he was Director of Clinical Training for the Harold Abel School of Psychology at Capella University in Minneapolis, Minnesota, and then taught, mentored, and served as core faculty until 2007. In 2001, Dr. Leichter returned to MeritCare Health System and continues to work as a clinical psychologist in a rural primary health care clinic. He has been an adjunct assistant professor with St. Mary's University in Minneapolis and core faculty member in the Psy.D. program in clinical psychology at Capella University. He is a member of the American Psychological Association, Minnesota Psychological Association and Arizona Psychological Association. He is licensed to practice psychology in Michigan, Minnesota, and Arizona. He is also listed in the National Register of Health Service Providers in Psychology, holds the Certificate of Professional Qualification (CPQ) from the Association of State and Provincial Psychology Boards, and was an associate editor for the journal *Professional Psychology: Research and Practice* from 2000-2006. In 2010, Dr. Leichter was appointed by Governor Pawlenty to the Minnesota Board of Psychology.

Donald Preussler Ph.D., L.P., Assistant Clinical Director

Dr. Preussler received his Ph.D. in clinical psychology in 1989 from the University of North Dakota and did his residency training at the University of Texas Medical School in Houston, TX. He did his post-doctoral work in clinical child psychology and holds a masters degree in human development. He is a licensed psychologist in the states of Minnesota and Illinois and is a member of the National Association for Rural Mental Health as well as other professional organizations in the fields of psychology, medicine and religion. His professional background includes over fifteen years of academic employment and various clinical positions including administrative and supervisory responsibilities for all levels of training in clinical psychology. His research interests have been in the areas of psychometric assessment, the integration of psychology with health and religion, psychopharmacology and most recently rural psychology. He is currently employed by MeritCare Clinic in Detroit Lakes, MN.

Jonathan Aligada Psy.D., L.P.

Dr. Aligada did his graduate work at Argosy University, Minneapolis, Minnesota and completed his post-doctoral residence through the MCARPT program. Since graduation, Dr. Aligada has directed the new behavioral health and geropsychology program at Innovis St. Mary's Hospital in Detroit Lakes, MN. There, he consults to primary care physicians and sees patients of all ages for individual psychological services in addition to serving the aged population at Oak Crossing extended care facility.

Gary Bowman Ph.D., L.P.

Dr. Bowman received his doctorate in counseling psychology at the University of Minnesota in 1996. His dissertation examined the separation and individuation of adolescent females in families with parental alcoholism. He is licensed as a psychologist

in the state of Minnesota and as a marriage and family therapist in Wisconsin. He is currently employed by Lakeland Mental Health Center in Detroit Lakes with an emphasis on adolescent and adult outpatient care, typically addressing mood disorders, chronic pain, and relational concerns. Prior to joining Lakeland, Dr. Bowman was employed at St. Luke's Hospital in Duluth, Minnesota, where he provided clinical supervision as well as outpatient individual, relational, and systemic therapy to a wide variety of clients.

Brian Gatheridge Ph.D., L.P.

Dr. Gatheridge was born and raised in the rural NW Minnesota town of Kennedy. He earned his bachelor's degrees in psychology and sociology from North Dakota State University (NDSU) in 2001. Subsequent to graduation he enrolled in the clinical psychology graduate program at NDSU, earning his master's degree in 2003. From there he enrolled in the doctoral program in clinical psychology (child and adolescent emphasis) at Washington State University, earning his Ph.D. in 2007. Through the academic year of 2006-2007 he worked to complete his predoctoral internship training in pediatric psychology through the University of Minnesota Medical School. His postdoctoral fellowship was completed through the MCARPT program in 2007-2008. It was through the MCARPT program that his fondness for rural practice was enhanced and subsequent to the end of his fellowship he accepted a position with MeritCare Health System. In this position he works as a licensed psychologist in and around the Detroit Lakes community, while also remaining involved in the MCARPT program as a clinical supervisor.

Don Janes, M.S., L.P.

Mr. Janes is licensed psychologist. He has worked several years in community mental health. He currently supervises children's mental health and developmental services and chemical dependency services at Becker County Human Services. Mr. Janes obtained his bachelor's degree in 1976 in sociology and psychology from Northern State College in Aberdeen, South Dakota. He went on to earn his master's degree in community counseling psychology from St. Cloud State University. He then went on to do additional training in marriage and family therapy at St. Mary's University in Minneapolis. Before taking on his job with Becker County Social Services, he worked for Lakeland Mental Health Center for 10 years, both as a psychologist and later as the adult services director.

SARA JENSEN-FRITZ M.S., L.P.

Sara is a graduate of the University of North Dakota (BA, Psychology), North Dakota State University (MS, Psychology-Clinical Behavior Analysis), and Moorhead State University (PsyS, Specialist Degree, School Psychology). The first part of Sara's career was spent in a clinical setting at Southeast Human Service Center in Fargo, ND, where she completed psychological evaluations, behavioral consultations and was involved with individual and group therapy. Sara became a Licensed Psychologist in 1998. Currently, Sara is a School Psychologist for Detroit Lakes School District. She conducts special education evaluations and is an active participant on student assistance teams and child study meetings. As a member of these teams Sara consults with teachers and parents to develop individual and classroom interventions.

Gail Pickett, Ph.D., L.P.

Gail considers a small community in Northeast Missouri to be her hometown. Growing up in a community of 2,000 people and graduating from a high school class of 74 provided her with front row knowledge of what "rural" means. Working with a consortium dedicated to providing post-doctoral training to psychologists desiring to work in rural communities is exciting and a "good fit" for her.

Gail earned her undergraduate degree in secondary social studies education from the University of Missouri - Columbia in 1983. Master's degree (1993) and doctorate (1998) in clinical psychology were earned at the University of Missouri - St. Louis. Pre-doctoral internship was with the VA Medical Center, Jefferson Barracks campus in St. Louis. Gail's research focus centered around PTSD and trauma issues, including the effects of trauma work on the therapist. She worked for the state of North Dakota in a regional outpatient "human service center" for almost seven years before coming to Minnesota. This opportunity has allowed her to appreciate the need for good collaboration between and among treatment providers when working with clients of all ages and needs within a rural setting.

Sue Sailer LSW

Director of Social Services, Perham Memorial Hospital & Home. Sue graduated with a Bachelor's Degree in Social Work, with minors in Psychology & Sociology from Bemidji State University, May 1977. She has maintained social work licensure through the State of MN since licensing began with the MN Board of Social Work. She started working on her Master's degree in Social Work with an emphasis on Indian Child Welfare through the University of MN-Duluth. She has had a wide range of social work experiences in the past 25+ years, including: child protection, chemical dependency, mental health, geriatrics, medical social work, hospice and end-of-life care. The majority of her experiences have involved social work in the medical delivery system. Advocacy for patients and assisting them to navigate health challenges is the most rewarding portion of her work. Sue advises: "Maintaining a sense of humor is crucial."

James Torkildson Ed.D., L.P.

Dr. Torkildson earned his B.A degree in Psychology from Moorhead State University (1979), his M.A. degree in Counseling Psychology from Ball State University (1984) and his Ed.D. degree in Educational Psychology and Counseling from the University of South Dakota in 1986. He has worked in community mental health for approximately 15 years and served as Chief Psychologist for a long term placement children's home. He has also worked as a professor of psychology while residing in Indiana. Dr. Torkildson returned to Minnesota in 2002 at which time he accepted the position to serve as the Director of the School Based Mental Health project for the Otter-tail County Family Services Collaborative. In July of 2007 he left this position to assume the clinical director role for Lakeland Mental Health Center in Detroit Lakes. He is now a private consultant. He is a Licensed Psychologist in the State of Minnesota.

Darryl Zitzow Ph.D., L.P.

Dr. Zitzow earned his master's degree in clinical psychology from the University of North Dakota in 1975 and completed his Ph.D. in psychology from Walden University in 1980. He is licensed as a psychologist in both Minnesota and South Dakota and also holds licensure as a social worker in Minnesota. He completed his doctoral internship at Aberdeen State University in South Dakota. He worked as a professor of psychology at Northern State University in South Dakota for 10 years where he directed the campus counseling center. He has worked for Indian Health Services on the White Earth Reservation since 1985 where he directs the mental health service. His clinical interests and specializations include Native American emotional/behavioral adjustment issues, suicide among Indian youth, gambling addiction, and family development issues among Native peoples.

XII. Graduate Capstone Project

The MCARPT program requires that each psychology resident complete a graduate capstone project by the end of the training year. The exact nature of the project will be determined in consultation with the clinical director but may include, for example, a research project, program evaluation, development of new program for one or more consortium members, or other contribution to the communities that MCARPT serves, members of the consortium, or to future residents in the program. The project will serve to enhance existing mental health services or to develop and sustain new and innovative service delivery methods and models. Time may be set aside for the resident to develop a prospectus, evaluate appropriate professional literature, design the project, and carry it through to implementation under the supervision of MCARPT professional staff. However, residents should begin considering, early on in the training year, the nature of the project that they would like to pursue and to begin to discuss this with the clinical director. Successful completion of the capstone project is a prerequisite for graduation from the MCARPT fellowship program. Residents may contact the clinical director for information on past projects successfully submitted by previous trainees.

XIII. Resident Evaluation

While residents are considered professionals-in-training, evaluation of performance and competency is an important aspect of the MCARPT program. Evaluation of residents serves the purpose of: 1) Protecting the welfare of consumers of services provided by residents, 2) Providing detailed feedback to residents regarding both clinical strengths and areas of needed improvement which permits the resident to continue to hone their individual clinical progress and 3) Protecting the integrity of the MCARPT program and member sites and ensuring the highest quality and professionalism of residents and their activities. The MCARPT program values ongoing evaluation as an avenue to shape residents to become clinical and community leaders in rural healthcare roles.

Psychology residents will be evaluated at the end of each quarter and at the end of each training year. The clinical director will also routinely consult informally with rotational supervisors to ascertain resident performance. Annual feedback will be substantive in

nature and will be detailed enough to provide the resident with a framework for continued improvement, growth, and where needed, self-correction. Feedback will address the resident's performance and progress in the areas of professional conduct and psychological knowledge, diagnostic and intervention skills, consultation, teaching, program evaluation and development, ethics, collaboration skills, teaching (where indicated), and leadership. Evaluation will take the following forms:

1. **Supervisor Rating Forms:** At the end of each quarter, the clinical director will distribute and collect rating and evaluation forms to site supervisors. Supervisors will be asked to evaluate residents on a number of different domains covering clinical acumen and also professional conduct, ethical behavior, interpersonal skills, and overall performance. Copies of the supervisor rating forms will be used as a foundation for individual supervision and will also be contained in the clinical portfolio.
2. **Individual/Group Supervision:** Each resident receives at least one hour weekly of individual supervision and 1 1/2 hours weekly of group supervision. This will include supervision from the clinical director, assistant clinical director, or another psychologist or mental health professional as designated by the director. A brief evaluation of the resident's progress in supervision will be reported in both rotational evaluations and in the yearly review.
3. **Yearly Resident Evaluation:** At the end of the training year, the clinical director, with assistance from site supervisors, will create an annual summary of the resident's performance across all domains with documentation of strengths and needed areas of improvement. Any site supervisor may have input into the annual evaluation. Evaluations will be discussed with the resident, comments from the resident will be included in the document, and it will become part of the resident's training record.

In order to graduate with a certificate of completion from MCARPT, the resident must successfully complete all assigned rotations and clinical activities, must achieve satisfactory ratings in all rotations, assignments and functions as determined by clinical supervisors, must pass the final resident evaluation by the Director of Training and must receive approval on their graduate capstone project.

XIV. Stipend and Benefits

For training cycle 2010-11, MCARPT offers the following benefit package:

- \$40,000 stipend
- Medical and Dental benefits through the standard professional employee package of Sanford health system with Sanford Health insurance (this will include a required monthly resident contribution depending on the size of the family).
- Disability insurance
- 17 days paid time off (PTO) for vacation and sick leave.
- 6 additional days paid holiday (New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, and Christmas Day)
- Up to \$1000 in moving expenses (documentation required)

- Paid malpractice insurance
- \$1000 towards continuing professional education (must be pre-approved by clinical director but may include costs of attending conferences, symposia, workshops, etc. or the cost of purchasing books, videos, tapes, etc. which are substantially psychological in nature or relate directly to rural mental health issues)
- \$75/month mileage stipend

XIV. Professional, Ethical, and Legal Issues During Residency Training

This section is intended to provide guidelines to residents and supervisors on professional, ethical, and legal issues which may arise during residency training. This is not meant to be a complete or exhaustive review, nor should it be construed to function in place of individual consortium site policy and procedure manuals. Residents are required to become familiar with rules, regulations, and policies of conduct for each training site where they are placed. MCARPT subscribes to the ethical guidelines of the American Psychological Association (Ethical Principles of Psychologists and Code of Conduct, APA, 2002) and to statutes contained within the Minnesota Board of Psychology Practice Act (Available from the board at 612-617-2230). Residents are expected to be familiar with both of those guidelines.

A: Confidentiality

Confidentiality has traditionally been accepted as a cornerstone of delivering professional psychological services in any clinical setting. Most practicing therapists agree that maintaining privileged communication and delivering services in a confidential manner are critical ingredients in effective therapeutic service delivery. The APA (Standard 4.01) notes that:

“Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship.”

Issues around confidentiality and exceptions to those issues are often perplexing to trainees and supervisors alike who seek to maintain client confidence in a world filled with litigation, observation of work by others, demands for release of information from insurers, and a myriad of other threats to the sanctity of the traditional therapeutic relationship. Residents who are unsure of these issues must consult with supervisors for clarification as well as risk managers. Several instances exist in which confidentiality is not viewed by the courts as the paramount concern:

→ The 1969 case in which Tatiana Tarasoff was murdered by Prosenjit Poddar led to the 1974 California Supreme Court decision, now referred to as the “Tarasoff Decision” which states that under certain circumstances, there exists a “duty to warn” which supersedes patient confidentiality. The Tarasoff decision dictates that when a therapist determines that his/her client presents a serious and imminent threat of violence to another, the therapist incurs a serious and legally mandated obligation to use reasonable care to protect the intended victim from such danger and to notify law enforcement

authorities. This is carried out without the necessity for patient consent as the law has held that this supersedes the importance of client confidentiality. See Minnesota Psychology Practice Act, 7200.4700, subparagraph 2, **Disclosure without written consent.**

→ States have held that psychologists and psychology trainees are legally mandated reporters of child abuse and neglect as well as abuse of vulnerable adults. While individual states vary in their interpretation of the law, most states require mental health professionals to provide both verbal and written documentation to social service authorities of suspected neglect and abuse of these populations even in the absence of client consent. This can present serious threats to the therapeutic relationship. See Minnesota Psychology Practice Act, 7200.7400, subparagraph 11, **Abuse of children and vulnerable adults.**

→ In a similar fashion to the Tarasoff decision regarding harm to others, states have held that serious and imminent threats of harm to self require therapists to act in the interests of the client to preserve and protect life even if this means violating patient confidentiality to do so. This can also create complex and difficult implications for the therapeutic relationship. See Minnesota Psychology Practice Act, 7200.4700, subparagraph 2, **Disclosure without written consent.**

→ Cases in which a judge order the release of therapy or treatment records even without consent of the client can also present the trainee or the seasoned mental health professional with significant difficulties. While this may be a direct affront to the ethics of the profession, therapists are ordinarily obligated to release records to a court when ordered to do so by a judge. See Minnesota Psychology Practice Act, 7200.4700, subparagraph 10, **Release of private information.**

Each of the above situations requires the psychology resident to seek immediate and ongoing consultation with their designated supervisor, or in some cases, the agency risk manager.

B: Suicidality

Unfortunately, most psychologists-in-training will encounter a professional situation, at some time during their training, which will require assessment of suicide, lethality, and dangerousness. Psychology trainees are ethically bound to recognize what specific symptoms are associated with suicide and how and when to seek supervision in this area. Residents who encounter issues around suicide should immediately seek ongoing supervision and consultation. Competent professional consultation is vital in situations where there is risk of loss of life. Signs and symptoms which indicate potential risk for suicidal behaviors include:

- ✓ Previous suicide attempts
- ✓ Untreated depression
- ✓ Verbalizing feelings of death and dying, planning, and ideation of suicide.
- ✓ Alcohol and/or drug abuse.
- ✓ Recent serious psychosocial stressors.

- ✓ Personally relevant anniversary dates of loss or grief.
- ✓ Poor level of psychosocial support.
- ✓ Giving away of personal possessions.

C: Professional Competence

Principle D of the APA Ethical Principles of Psychologists and Code of Conduct (2002) speaks to the obligation of psychologists maintaining high standards of competence in their work. As noted, psychologists:

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

Psychology residents are cognizant of their “trainee” status and must seek ongoing supervision to effectively deal with clinical cases and situations that are assigned to them. They use supervision wisely and efficiently and strive to constantly add to their knowledge base. They recognize their own limitations and the ways in which these limitations can affect their efficacy and ethical behavior.

“There is nothing more dangerous than ignorance being practiced.”
--Johann Wolfgang von Goethe

See also the Minnesota Psychology Practice Act, section 7200.4600, subparagraph 1, **Limits on Practice** and subparagraph 3, **Consultation with other Professionals**.

C: Sexual Harassment

Psychology residents in the MCARPT program are expected to be sensitive to workplace conditions that are in direct opposition to professional standards of behavior and practice. The APA Ethical Principles (Standard 3.02) of 2002 explicitly states that:

“Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or non-verbal conduct that is sexual in nature, that occurs in connection with the psychologist’s activities or roles, as a psychologist that either: (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment and the psychologist knows this or is told this: or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context.”

Psychology residents are expected to be sensitive to other forms of harassment that may be perceived as demeaning that include, but are not limited to: Another person’s age, gender, ethnicity, national origin, religion, ancestry sexual orientation, physical or mental disability, medical condition, language, marital status or socioeconomic status. Residents who knowingly engage in any form of harassment are subject to disciplinary action by the Clinical Director and /or Board of Directors of MCARPT.

D: Professional Relationships

Psychology residents are expected to act as professional psychologists-in-training at all times while on clinical rotations and carrying out duties associated with MCARPT training experiences. This includes, but is not limited to maintaining professional boundaries and relationships with colleagues, supervisors, subordinates, and consumers. If a resident is approached by a colleague or consumer in a manner that the resident feels is unprofessional, it is expected that the trainee will report this action to his/her site supervisor.

E: Dress Code

Psychology residents are expected to respect the dress code that is appropriate to the consortium host site where they are working. The MCARPT program recognizes that different member sites will adhere to standards of dress which best fit the population, location, culture, and mores of that facility. Residents are expected to regard those standards when choosing proper professional attire.

F: Respecting Diversity

As described in the Ethical Code of Conduct of the American Psychological Association (2002), Principle E is entitled “Respect for People’s Rights and Dignity.” Residents should familiarize themselves with this part of the code and are expected to be sensitive to client/patient/consumer rights to privacy, confidentiality, cultural differences, gender, religious preference, sexual orientation, disabilities, ethnicity, race, language, socioeconomic status, and other factors which may label an individual as different. As psychologists-in-training, MCARPT trainees must work to eliminate their own personal biases or prejudicial beliefs toward their communities and client populations. Residents, where appropriate, also work to eliminate bias and promote tolerance in those with whom they work.

XV. Resident Impairment

The faculty and board of directors of MCARPT hold residents to the highest ethical and professional standards for the learning and practice of clinical psychology. The program recognizes, however, the inherent stresses involved in undertaking rigorous post-doctoral training which can interfere with optimal performance and progress. This section documents expectations, policies, and procedures of MCARPT related to resident impairment and subsequently to due process.

Definition of Terms and Concepts

MCARPT is committed to a competency model of professional psychology training for practice in rural communities. For purposes of this training manual, **competence** must be demonstrated and evaluated behaviorally. In its training, education, and evaluation procedures, MCARPT is committed to providing residents a high quality clinical, educational, and training experience. However, MCARPT also recognizes its

commitment to the public welfare and to the profession in that resident trainees are competent to practice and function as professional psychologists.

MCARPT recognizes that competence takes two forms. First, are *core competencies*. This refers to the resident's ability to perform the various proficiencies (knowledge, academic, and practice) associated with the program's central themes of mastery of core objectives related to rural practice. Second, *readiness for independent practice*, is determined by the training faculty based on appropriate professional standards for clinical psychologists. Readiness for practice is defined by the resident being able to demonstrate the following:

1. Meet the behavioral requirements and attitudinal standards of the APA Ethical Principles of Psychologists and Code of Conduct (2002).
2. Demonstrate the capacity to receive supervisory feedback in many venues in a non-defensive and open manner. In this context, "non-defensive" acceptance of feedback does not preclude attempts to clarify and understand the feedback offered, or its implications, nor are trainees expected to accept inappropriate or erroneous feedback, or feedback based on other than objective, or normally accepted measures of trainee progress. In this context, "non-defensive" might mean an appropriate appeal to a relevant higher authority using standard methods of evidence-based argumentation and scholarly discourse. Further, "non-defensive" is not intended to mean blind or unreflective compliance.
3. Demonstrate the capacity to self-monitor, including recognizing where their performance or training may be inadequate or sub-standard or insufficient and identify ways to remedy the recognized deficiency. In this regard, "self-supervise" means to master a skill that embodies or demonstrates the attitudes and commitments essential to the practice of psychology.

Psychology residents may have difficulty demonstrating their competencies or preparation for independent practice. Ordinarily, this can come from one or more of several different pathways. Each of the pathways can result in the failure to demonstrate competence or readiness, but all have different meanings and require different responses from the MCARPT program.

- A. **Incompetence:** This denotes a condition in which the resident is not able, after appropriate instruction and training, to demonstrate competence to the minimum level and has not ever achieved or demonstrated the competence in question while a resident in the MCARPT program. Specifically, incompetence indicates that the resident trainee has never achieved even minimum baseline standards of proficiency or readiness for independent practice as determined by clinical faculty.
- B. **Impairment:** This denotes a condition in which the resident ceases to be able to demonstrate minimum proficiency in any of the domains of competence and is reflected in one or more of the following ways:
 1. An inability and/or unwillingness to acquire and integrate professional standards into one's own repertoire of professional behavior and ethical standards.
 2. An inability to acquire professional skills in order to reach an acceptable level of competency.

3. An inability to control personal stress, strong maladaptive emotional reactions, substance abuse/dependence, and/or psychological dysfunction, which interfere with professional functioning. In this context, “personal stress” and “psychological dysfunction” can encompass many issues such as mental illness, interpersonal problems, marital/relationship distress, physical illness or injury, burnout, and so forth. The key element is that the source of distress can reasonably be expected to yield to time and/or treatment and that the resident’s performance can be expected to return to pre-morbid levels of competence.

Ultimately, it is matter of professional judgment as to when a resident’s behavior becomes impaired rather than simply problematic. However, for purposes of this policy, **a problem refers to a resident’s behaviors, attitudes, or characteristics, which, while of concern and requiring remediation, are not perceived to be unexpected or excessive for professional psychologists in training.** Problems typically can be expected to become impairments when they include one or more of the following characteristics:

C. Problematic

1. The resident does not acknowledge, understand, or address the problem when it is identified.
2. The problem is not merely a reflection of a skill deficit, which can be rectified by academic or didactic training or additional supervision.
3. The quality of services delivered by the resident in a consortium site is sufficiently negatively affected and may be considered to be unhelpful or detrimental to other staff or trainees, clients, or consumers of delivered services.
4. The problem is not restricted to one area of professional training.
5. A disproportionate amount of attention by supervisors or other training staff is required as compared to similarly placed resident trainees.
6. The resident’s behavior does not change as a function of feedback, remediation efforts, and/or time.
7. Multiple and similar observations are made by more than one clinical or field supervisor or other MCARPT personnel.

D. Disability

This concept is distinguished from impairment in that: (1) The resident demonstrates psychological or physical difficulties that meet the Americans With Disabilities Act (ADA, 1991); (2) The resident has declared this disability at the onset of the training program; (3) The condition causes performance of any proficiency or demonstration of readiness for practice to fall below minimum standards set by the MCARPT program. Disability will not delay a resident’s progress through the training fellowship if, with reasonable and agreeable accommodations, the resident’s performance of proficiencies and demonstration of readiness for independent practice can reach at least minimum standards set by the program.

E. Unethical Behavior

This concept refers to documented behavior that is in clear and direct violation of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (2002). Unethical behavior may be a sign of impairment in certain situations. To be considered a sign of impairment, the behavior in question must continue after the resident has been notified of the infraction, its relation to the APA code, and the resident has agreed to correct the behavior in question.

F. Illegal Behavior

This refers to behavior that has resulted in the resident being charged, or is reasonably expected to be charged, by a competent jurisdiction, with a crime that implies or demonstrates an ethical violation as well as a violation of federal, state, or local laws. Specifically, any illegal behavior that could cause harm to or negatively affect a client, patient, colleague, staff member, supervisor, fellow trainee, subordinate, or other stakeholder in the MCARPT program falls under this definition. Behavior that is charged but does not affect the stakeholders of the MCARPT program will not be considered relevant to the trainee's progress. Illegal behavior will be handled separately from the process of impairment, in accordance with policies and procedures of participating agencies of the MCARPT consortium.

XVI. Procedures for Responding to Impaired Performance

Due process ensures that decisions made by the MCARPT program about residents are not arbitrary, capricious, or biased by personal or outside factors. Any interested stakeholder may express concern about a resident's performance. Initially, this concern should be taken up directly with the resident in order to informally resolve concerns. However, in cases where this is not possible or not appropriate, concerns should be directed to the resident's primary supervisor as soon as possible. In situations where that level of intervention does not resolve the problem or in cases where that is not feasible or advisable, the clinical director of the MCARPT program will investigate concerns of resident impairment. The **clinical director** will review the situation in consultation with the parties involved including the resident within a reasonable period of time of receiving notification and will issue a written report which becomes part of the resident's training file. The review will focus on issues surrounding the nature of the suspected impairment. Possible outcomes of this investigation include:

1. The clinical director may elect to take **no further action** after review of the identified situation.
2. The clinical director may issue an **acknowledgment notice**, which formally states the following:
 - A. The director is aware of and concerned about the behavior in question.
 - B. The situation has been brought to the resident's attention and the director or other supervisors will work with the trainee to rectify the problem within a specified time frame.

- C. The behaviors associated with the impairment are not significant enough to warrant more serious action at this time.
3. The clinical director may issue a **probation notice**, which specifies that the director will actively and systematically monitor for a specific length of time the degree to which the resident addresses changes and/or otherwise improves the problematic issues. The probation notice is a written statement, to be included in the resident's training file, that includes a description of the problematic behavior, specific recommendations for rectifying the problem, a time frame for the probation during which the problem is expected to be resolved, and procedures to assess whether the problem has been appropriately resolved.
 4. The clinical director may deem that prescriptive remedial action is necessary given the gravity of impairment and will issue a **mandatory remediation notice** which also includes, as noted above, a description of the problematic behavior, a time frame for remediation, and procedures to assess whether the problem has been appropriately resolved.

Domains of Remediation

The clinical director, after reviewing all relevant information, may elect to prescribe one or more of the following remediation formats to the resident in the mandatory remediation notice.

- A. Personal Psychotherapy: The clinical director of MCARPT may elect to recommend to the resident that he/she obtain professional intervention (counseling, psychotherapy, substance use treatment, etc.) services to address mental or emotional difficulties that may be perpetuating impairment. The resident would be responsible for any and all costs associated with such intervention. MCARPT faculty would not serve in the capacity of treating therapist so as to avoid difficulties with multiple relationships as outlined in APA standard 3.05.
- B. Repeat Rotation: This path of remediation is available to the clinical director if the impairment primarily is of a nature that could be satisfactorily resolved by repeating the training experience. This response may well be paired with other responses to maximize the rehabilitation of the resident.
- C. Leave of Absence: If the impairment is found to be primarily related to stressful life circumstances, the resident may be asked to remove him/herself from active enrollment in the MCARPT program in order to settle or resolve those issues which have prevented the trainee from successfully advancing through the fellowship program. Readmittance to the program will be assessed in conjunction with the clinical director who will determine the resident's suitability for return to active training status.
- D. Increased Supervision, Advising, or Mentoring: Depending on the nature of the impairment, the clinical director may direct that the trainee receive additional supervision in a particular issue or domain, which is intimately related to the impairment behavior. This remediation is likely to be useful only when the resident's impairment is narrowly focused, circumscribed, and easily identified.
- E. Self-Structured Behavior Change: This may occur in situations where the nature of the impairment allows for the resident and a faculty representative to negotiate a

personal change process without complex or prolonged involvement of the program beyond the initial recognition of the concern.

- F. **Suspension of Direct Service Activities:** If the resident is involved in professional psychological training experiences which involve direct clinical service activity, the clinical director may elect to suspend any further psychological activities until the trainee has demonstrated the ability to rectify the behavior(s) in question.
- G. **Schedule Modification:** This is a time-limited, remediation-oriented, closely supervised period of training designed to return the trainee to a more fully functioning state. Modifying a resident's schedule is an accommodation made to assist the trainee in responding to personal reactions to identifiable environmental stress, with the full expectation that the trainee will complete his/her fellowship training. This period will include more closely supervised training, supervision, and oversight.

Failure to Correct Problems

When a combination of interventions, instruction, supervision, and remediation does not adequately rectify the impairment within a reasonable and prescribed period of time, depending upon the specific infraction or concern, or when the resident seems unable or unwilling to alter his/her behavior in accordance with the recommendations of the clinical director of MCARPT, the program may elect to take a more formal and permanent action. If a resident has been issued an **acknowledgment notice, probation notice, or mandatory remediation notice**, and has not improved sufficiently to rectify the problem under the conditions stipulated by the clinical director, a formal review will occur and the resident informed that the conditions for revoking the specific notice have not been met. The clinical director will then proceed in one of the following two ways:

1. The clinical director may elect to continue the probation for another specified time period if it appears that some improvement has been made subsequent to the original notice.
2. The clinical director may recommend to the MCARPT Board of Directors that the resident be dismissed from the post-doctoral fellowship program. Dismissal or termination is reserved for cases in which there are severe, repeated, or egregious violations of the APA Code of Ethics, Minnesota Psychology Practice Act, malicious and intentional violation of the welfare of others (colleagues, faculty, other trainees, co-workers, subordinates, other stakeholders, etc.) or when imminent harm to a client or consumer is a major factor in the impairment.

XVII. Resident Grievance Procedures

Due process ensures that decisions made by the MCARPT program supervisors about trainees are not arbitrary, capricious, or based on bias or personal feelings. Due process requires that programs identify specific evaluative procedures available to the resident so he/she may understand and respond to the actions taken by the program.

Residents who receive a notice of **acknowledgment, probation, or remediation** or who otherwise may have cause to be dissatisfied with their status within the MCARPT program are entitled to file a grievance with the program. Within a reasonable time of receiving a notice as above, the trainee must inform the clinical director in writing that

he/she is challenging the findings of the clinical director with regard to behaviors or actions on the part of the trainee that have been adjudicated by the director. The resident will include in their grievance, information as to why the resident believes the actions of the clinical director are unwarranted. Failure to provide such information will constitute a rejection of the appeal and withdrawal of the challenge. A grievance may only be filed if the resident has evidence to suggest that either: (1) He/she was not given the opportunity to fairly and justly present data to refute conclusions about their impairment or (2) The decision made by the clinical director was arbitrary, capricious, reckless, or not based on professional standards. Following receipt of the resident's substantiated grievance within the specified time frame, the MCARPT board of directors will convene and conduct a review of the situation in question within a reasonable time of receiving the substantiated appeal. After the hearing, which may include interviews of the resident and other pertinent parties to the situation, and review of any supporting documentation, the Board will prepare a written report of their findings, decisions, and recommendations and inform the trainee of the decision. This decision will become part of the resident's permanent training record and is considered final and binding.

Appendix A Supervisor Rating Form

Supervisor Evaluation Form
 Minnesota Consortium for Advanced Rural Psychology Training
 MCARPT
 (Based on Hall-Marley, 2000, Therapist Evaluation Checklist and others)

1. Name of Psychology Resident _____
2. Name of Supervisor _____
3. Date of Evaluation _____
4. Agency Name _____
5. Time Period of this Evaluation (please circle)
- Summer Quarter (July-September)
- Fall Quarter (October-December)
- Winter Quarter (January-March)
- Spring Quarter (April-June)

Directions to Supervisor: *Accurate evaluation of the psychology resident is essential to his/her professional development. The purpose of this evaluation is to provide the psychology resident with succinct feedback regarding his/her performance in the fellowship program over the past 90 days. Please rate the resident's performance in comparison to the standard you would expect of other trainees at similar levels of education, training, and development. In addition to the numeric ratings, you may add narrative comments under each section and also summary comments at the end of the form. Please try and offer ratings for each item that you have been able to assess in the last quarter. Please mark **NA** for any items that you do not feel capable of accurately assessing or those items which were not part of the rotational experience.*

- 1= Far below standard; serious concerns; poor performance**
2= Below standard; some concerns; somewhat poor performance
3= Standard; no concerns; average performance
4= Above standard; good work; above average performance
5= Far above standard; excellent work; excellent performance
NA= Not applicable; not able to assess

I. Contributions to the Clinical Team

- | | | | | | | |
|---|---|---|---|---|---|----|
| 1. Resident is conscientious and fulfills designated responsibilities | 1 | 2 | 3 | 4 | 5 | NA |
| 2. Resident forms positive relationships with professional
and support staff of the agency | 1 | 2 | 3 | 4 | 5 | NA |
| 3. Resident exercises good judgment when acting independently | 1 | 2 | 3 | 4 | 5 | NA |

- 1= Far below standard; serious concerns; poor performance**
- 2= Below standard; some concerns; somewhat poor performance**
- 3= Standard; no concerns; average performance**
- 4= Above standard; good work; above average performance**
- 5= Far above standard; excellent work; excellent performance**
- NA= Not applicable; not able to assess**

4. Resident contributes to team planning and cohesion in meetings	1	2	3	4	5	NA
5. Resident’s behavior reflects positively on the agency	1	2	3	4	5	NA
6. Resident acknowledges contributions of other team members	1	2	3	4	5	NA
7. Resident is prepared and organized in assigned work	1	2	3	4	5	NA

Comments

II. Capacity for Professional Development

1. Resident is appropriately self-aware and open to self assessment	1	2	3	4	5	NA
2. Resident non-defensively accepts critical feedback	1	2	3	4	5	NA
3. Resident is eager to learn by seeking information and help	1	2	3	4	5	NA
4. Resident maintains openness to alternative points of view	1	2	3	4	5	NA
5. Resident demonstrates commitment to professional development	1	2	3	4	5	NA

Comments

III. Psychotherapy Skills

1. Resident appropriately identifies short and long term goals in treatment setting with clients	1	2	3	4	5	NA
2. Resident can appropriately adjust therapy goals as needed	1	2	3	4	5	NA
3. Resident can attend to timing, pacing, and rhythm of sessions	1	2	3	4	5	NA
4. Resident adjusts interventions to match client capacities	1	2	3	4	5	NA
5. Resident can select interventions based on appropriate clinical conceptualizations of a case	1	2	3	4	5	NA
6. Resident recognizes and attends to client resistance	1	2	3	4	5	NA
7. Resident can recognize and appropriately work with client transference issues	1	2	3	4	5	NA
8. Resident can recognize and appropriately work with their own countertransference to clients	1	2	3	4	5	NA

- 1= Far below standard; serious concerns; poor performance**
2= Below standard; some concerns; somewhat poor performance
3= Standard; no concerns; average performance
4= Above standard; good work; above average performance
5= Far above standard; excellent work; excellent performance
NA= Not applicable; not able to assess

9. Resident can successfully utilize the therapeutic alliance as an intervention tool in therapy	1	2	3	4	5	NA
10. Resident can appropriately utilize interventions from a variety of psychotherapeutic schools as necessary	1	2	3	4	5	NA
11. Resident appropriately recognizes termination issues in the therapy relationship	1	2	3	4	5	NA
12. Resident can convey warmth, empathy and genuineness	1	2	3	4	5	NA
13. Resident demonstrates respect for all clients	1	2	3	4	5	NA
14. Resident understands and responds as needed to client emotions	1	2	3	4	5	NA
15. Resident can recognize both latent and manifest client issues	1	2	3	4	5	NA
16. Resident can keep sessions focused on client issues	1	2	3	4	5	NA
17. Resident attends to both verbal and non-verbal client cues	1	2	3	4	5	NA
18. Resident uses good clinical judgment in therapy situations	1	2	3	4	5	NA
19. Resident can attend to both process and content in therapy	1	2	3	4	5	NA
20. Resident maintains appropriate boundaries with client	1	2	3	4	5	NA

Comments _____

IV Assessment Skills

1. Resident shows ability to select appropriate data gathering tools, instruments, and tests to accurately assess client issues	1	2	3	4	5	NA
2. Resident can properly use cognitive/intellectual test instruments	1	2	3	4	5	NA
3. Resident can properly use personality test instruments	1	2	3	4	5	NA
4. Resident can structure and conduct a diagnostic interview	1	2	3	4	5	NA
5. Resident demonstrates competency in formulating a DSM diagnosis on 5 axes	1	2	3	4	5	NA
6. Resident can observe and describe client behavior	1	2	3	4	5	NA
7. Resident can produce a written report of client taking into account all relevant material including history, interview and relevant testing	1	2	3	4	5	NA
8. Resident can integrate assessment data into treatment plan and therapy interventions	1	2	3	4	5	NA

Comments _____

- 1= Far below standard; serious concerns; poor performance
- 2= Below standard; some concerns; somewhat poor performance
- 3= Standard; no concerns; average performance
- 4= Above standard; good work; above average performance
- 5= Far above standard; excellent work; excellent performance
- NA= Not applicable; not able to assess

V. Ethical Knowledge and Behavior

- | | | | | | | |
|--|---|---|---|---|---|----|
| 1. Resident demonstrates knowledge of 2002 APA Ethical Principles of Psychologists and Code of Conduct | 1 | 2 | 3 | 4 | 5 | NA |
| 2. Resident can apply APA principles in clinical practice | 1 | 2 | 3 | 4 | 5 | NA |
| 3. Resident can apply APA principles in professional relationships | 1 | 2 | 3 | 4 | 5 | NA |
| 4. Resident recognizes ethical dilemmas in clinical work | 1 | 2 | 3 | 4 | 5 | NA |
| 5. Resident displays maturity in discussing ethical issues | 1 | 2 | 3 | 4 | 5 | NA |
| 6. Resident interacts with clients, colleagues, supervisor, staff and other trainees in respectful and ethical manner | 1 | 2 | 3 | 4 | 5 | NA |
| 7. Resident understands limits of confidentiality and honors this in the therapy relationship | 1 | 2 | 3 | 4 | 5 | NA |
| 8. Resident understands and utilizes informed consent | 1 | 2 | 3 | 4 | 5 | NA |
| 9. Resident understands limits of competence | 1 | 2 | 3 | 4 | 5 | NA |
| 10. Resident displays behaviors consistent with APA values of beneficence, nonmaleficence, fidelity, responsibility, integrity justice and respect for people’s rights and dignity | 1 | 2 | 3 | 4 | 5 | NA |
| 11. Resident recognizes the role of diversity in client presentation | 1 | 2 | 3 | 4 | 5 | NA |

Comments _____

VI. Receptiveness to Supervision

- | | | | | | | |
|---|---|---|---|---|---|----|
| 1. Resident is open to supervision | 1 | 2 | 3 | 4 | 5 | NA |
| 2. Resident communicates regularly with supervisor | 1 | 2 | 3 | 4 | 5 | NA |
| 3. Resident appreciates importance of supervision | 1 | 2 | 3 | 4 | 5 | NA |
| 4. Resident comes prepared for supervision sessions | 1 | 2 | 3 | 4 | 5 | NA |
| 5. Resident incorporates supervisory feedback into practice | 1 | 2 | 3 | 4 | 5 | NA |
| 6. Resident actively seeks constructive feedback | 1 | 2 | 3 | 4 | 5 | NA |
| 7. Resident can process issues within the supervisory relationship including difficulties or conflicts, openly and non-defensively with clinical supervisor | 1 | 2 | 3 | 4 | 5 | NA |

Comments _____

Summary

1. Please list and discuss what you see as trainee strengths: _____

2. Please list and discuss what you see as trainee's specific areas of needed growth: _____

3. As the primary supervisor, has this trainee satisfactorily competed all assigned tasks and passed this rotation's obligations and expectations *for this academic quarter?*

_____ Yes _____ No _____ Other (explain)

Please indicate which of the following sources of data used to evaluate this resident (check all that apply)

_____ Direct Observation _____ Observation by other supervisory staff

_____ Review of audio/video tapes _____ Review of case notes/reports

_____ Group supervision _____ Individual supervision

_____ Other (please specify)

Signatures

Resident signature Date

Supervisor signature Date

MCARPT Director of Training

Date

Appendix B
Resident Evaluation of Clinical Supervisor

Resident Evaluation of Clinical Supervisor
(Based on Lehrman-Waterman and Ladany, 2001; and Hall-Marley, 2001)

Psychology Resident Name _____

Supervisor Name _____

Period Covered Quarter 1: October-December
(circle time period) Quarter 2: January-March
 Quarter 3: April-June
 Quarter 4: July-October

Purpose: As part of its ongoing quality improvement efforts, MCARPT seeks to solicit feedback on supervisory experiences of trainees. This information will be used to improve the supervision component of the fellowship experience.

Directions: *Answer the following questions with regard to your primary supervisor this quarter. Circle the number that most closely describes your feelings about the supervisory experience. Use the following scale to best answer each question.*

- 1** ***Strongly Disagree***
- 2** ***Disagree***
- 3** ***Neutral***
- 4** ***Agree***
- 5** ***Strongly Agree***

- 1. My supervisor promoted a sense of acceptance and support _____
- 2. My supervisor established clear supervisory boundaries _____
- 3. My supervisor recognized and supported my strengths _____
- 4. My supervisor established reasonable expectations for me _____
- 5. My supervisor helped me grow professionally _____
- 6. My supervisor was sensitive to the stress of the residency program _____
- 7. My supervisor helped me see mistakes as learning experiences _____
- 8. My supervisor encouraged me to question and challenge _____
- 9. My supervisor encouraged reflection and introspection _____
- 10. My supervisor created a collaborative environment for learning _____
- 11. My supervisor could admit shortcomings or limitations without
 undue defensiveness or discomfort _____
- 12. My supervisor was respectful of diversity in culture and thought _____
- 13. My supervisor was reliable and available for scheduled meetings _____
- 14. My supervisor assisted me in theoretical case conceptualization _____
- 15. My supervisor was well versed in ethical considerations _____
- 16. My supervisor offered practical and useful intervention ideas _____
- 17. My supervisor helped me understand and address countertransference _____

- 1 *Strongly Disagree*
- 2 *Disagree*
- 3 *Neutral*
- 4 *Agree*
- 5 *Strongly Agree*

- 18. My supervisor helped me identify areas of needed growth _____
- 19. My supervisor welcomed feedback about my needs in supervision _____
- 20. My supervisor's feedback was clear and understandable _____
- 21. My supervisor seemed knowledgeable in clinical psychology _____
- 22. My supervisor helped me deepen my understanding of psychology _____
- 23. My supervisor treated me with respect as a colleague _____
- 24. As a result of supervision I feel more clinically confident _____
- 25. Overall, I feel satisfied with my supervisory experience _____

Comments _____

 Psychology Resident Signature

 Date

 Supervisor Signature

 Date

 MCARPT Clinical Director

 Date

Documentation Guidelines for Psychology Residents

Proper documentation is essential to providing professional psychological services that are compliant with standards of the American Psychological Association (www.apa.org/practice/recordkeeping.html) as well as Medicare and other third party payers. Documentation serves the function of substantiating service delivery for reimbursement, providing a record of treatment to guide the clinician in creating and sustaining a treatment plan, and providing a guide to services for other clinicians in the event that the practitioner is unable to continue treatment with a client. Further, in the event that a practitioner may be called upon by regulatory or legal bodies to substantiate treatment, the psychological record can be invaluable in providing documentation which clearly shows the course, content, and relevant decision making process in the therapy relationship.

Psychology residents in the MCARPT program will be called upon to document any number of patient/client encounters. Most commonly, these will fall into the domain of **phone calls, psychological test reports, progress notes, and initial psychological evaluations.** *In cases where an MCARPT host agency has a standard format for documenting such encounters, the resident should utilize those standards as their preferred method for recording those encounters in the agency's medical record. In cases where the agency has no preferred or standard method of documentation or in cases where agencies do not routinely keep such records, the psychology resident will be informed by the following formats , at a minimum, to record and maintain patient meetings, encounters, visits, or therapy sessions.*

I. Phone Calls

Caller _____

Reason for Call _____

Date _____

Intervention/advice _____

Time _____

Phone number _____

Provider Name _____

Date _____

II. Psychological Test Reports

Patient Name
History #
Referral Question
Date(s) of Testing
Date of Report
Tests Administered
Time element for each test (administration/scoring/interpretation/report writing)
DSM-IV-TR Diagnosis
Medications
Relevant Background and History
Testing Observations
Results and Interpretation of Testing
Plan
Signature and Title
Signature and Title of Supervisor

III. Progress Notes

Patient Name
History #
Date
Time (spent with client)
DSM-IV-TR Diagnosis
Medications
Current GAF
Clinical Goals for This Session
Treatment Strategies
Mental Status Exam
Clinical Progress and Impressions
Plan
Signature and Title
Signature and Title of Supervisor

III. Initial Psychological Evaluation

Patient Name
Medical Record #
Gender
Date of Birth
Age (years and months)
Marital Status
Date of Evaluation
Place of Evaluation
Time
Referral Question
Background and History of Present Complaint

Behavioral Observations and Mental Status Examination
Impressions
DSM-IV-TR Diagnosis
Plan and Recommendations
Signature and Title
Signature and Title of Supervisor

Informed Consent to Psychotherapy in Training Sites

The MCARPT program fully adopts and follows the 2002 Ethical Principles of Psychologists and Code of Conduct in all professional matters. This document can be downloaded from www.apa.org/ethics. As trainees, psychology residents are expected to fully inform prospective clients of their training status, their requirements for supervision, the identity and credentials of their supervisor, and the fact that clinical cases may be discussed in individual or group supervision. In particular, psychology residents are directed to the following from the 2002 APA code:

Informed Consent to therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements, and 5.01, Discussing the Limits of Confidentiality.)

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

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given psychologist's work with clients or patients will be supervised, the above discussion includes that fact, and the name of the supervisor, when the supervisor has legal responsibility for the case.

Ethical behavior is a cornerstone of both professional psychology as well as the MCARPT program. Thus, psychology residents are expected at all times to adhere to the highest possible standards of ethical practice. MCARPT is a training program to prepare future psychologists for independent practice to rural communities. It is also a partner to several clinical agencies whose responsibility it is to provide mental health services to its constituents. Thus, psychology residents and the MCARPT program are in the sensitive position of protecting the welfare of psychotherapy clients while at the same time serving in a formal training program. This is further complicated by the fact that psychology residents serve in numerous different agencies during their training residency. These agencies have different policies, procedures, administrative entities, and professional parameters. At times, it may appear that these roles are not easily reconciled with one another. Clinical psychologists are frequently called upon to serve in complex ethical situations and are expected to do so professionally, competently, and in adherence to local, state, and federal guidelines. This includes compliance with the 1996 Health Insurance Portability and Accountability Act (HIPAA).

One of the requirements for any client served by MCARPT psychology residents is that they provide written informed consent which includes acknowledgment that confidential information may be shared not only in the course of obtaining ongoing supervision but that they also understand the legal limits of confidentiality in the state of Minnesota. This informed consent will clarify for consumers, among other things, what information will be revealed beyond the relationship with the psychology resident and under what circumstances. Informed consent means that clients have a clear understanding of the nature and parameters of the professional psychological relationship before entering into a formal contract with the trainee for provision of psychological services. The client's ability to understand all relevant information about the nature and potential future consequences of the decision are assessed in the process. Competence is a prerequisite for informed consent. In most jurisdictions, persons over the age of 18 years are presumed to be competent unless proved otherwise before a court. Minors under the age of 18 are presumed to be NOT competent to consent and thus a parent or legal guardian will consent on their behalf to psychological services.

Except in certain unusual circumstances (emergencies, instances of therapeutic privilege, etc.), it is mandatory that mental health professionals, including MCARPT trainees, obtain his or her client's informed consent before beginning a course of treatment. Failure to do so can serve as the basis of a claim of negligent non-disclosure. A mental health professional or trainee can avoid such claims by obtaining an adequate written consent from each of his or her clients. When clients are unable to consent (children, adults adjudicated as incompetent, etc.), psychology residents obtain consent from the appropriate party on behalf of the client (i.e. parent, legal guardian, etc.). Mental health professionals may be held liable for failure to obtain informed consent even if the treatment rendered is not deficient (see for example *Madsen vs. Park Nicollet Medical Center, 1988*).

A consent form can't realistically cover all the specific situations that may arise in any given clinical situation and thus forms are written vaguely and generally. This does not, however, in any way release psychology residents, or ultimately their psychologist supervisors, from the scrutiny of their actions. The following general guidelines regarding consent and confidentiality will be adopted by psychology residents in this area. ***Further, an MCARPT informed consent form (see below) will be obtained on EVERY new client that the psychology resident encounters in their training.*** The resident will provide a copy of this consent form to the client and give the other copy to the clinical director to be maintained by the MCARPT program.

1. Psychology residents get additional releases signed by clients or their agents before sharing information with anyone other than their primary supervisor, site supervisor, or MCARPT faculty. When in doubt, ask clients to sign additional releases.
2. Psychology residents only access treatment, consultation, or assessment records for their own clients unless there is appropriate authorization for them to review other files.
3. Psychology residents respect the privacy of other residents and the work they do in the same MCARPT training site. Residents do not seek information about other resident's work unless it is in the course of assigned training tasks, group supervision, or is part of the internal administrative review of an MCARPT affiliated agency.

4. Psychology residents are mindful of the ethical challenges of small towns and frontier communities. As such, trainees limit their conversations about clients to formal or informal supervision sessions in private venues with designated supervisors.
5. Psychology residents recognize that peer consultation with other trainees is an important aspect of post-doctoral training. Consultation, however, occurs only in private and client anonymity is assured by disclosing only that identifying information necessary to facilitate the peer supervision.
6. Psychology residents make every effort to protect files, reports, videotapes, audiotapes, test results and other written material pertaining to clients. Information left on personal computers is password protected and computers secured at all times. Confidential information removed from MCARPT training sites is held in strictest confidence and made inaccessible to anyone other than the trainee and his/her supervisor.
7. Psychology residents exercise extreme caution when using unsecured phone lines such as MCARPT distributed or personal cellular telephones. Client identifying information is held in strictest confidence when using this form of communication unless failure to identify the client would create a risk of harm to that client or identifiable others. Further, residents understand that e-mail is NOT a protected form of communication and thus, great care is used in conveying information with this medium and residents refrain from using this modality to convey confidential data.
8. Psychology residents make every effort to protect confidential client information that is on MCARPT distributed computers.

Minnesota Consortium for Advanced Rural Psychology Training (MCARPT)

Informed Consent for Psychological Services

(This form is available in carbon copy version for actual clinical use)

MCARPT is a one year training program for unlicensed doctoral -level psychology residents designed to prepare them to become professional practicing psychologists in rural and frontier communities. They are directly supervised in all clinical activities by psychologists who are licensed to practice in the state of Minnesota.

Before entering into psychological services with the psychology resident, you are entitled to know certain important information so that you can make an informed decision about receiving psychological care from this trainee.

1. All psychology residents are supervised by local Minnesota licensed psychologists who oversee and are responsible for all aspects of their clinical work. Supervising psychologists may not be employees of the agency where the service is offered.
2. Any notes, documents, or reports that are generated by the resident's work with you will be co-signed by a licensed psychologist supervisor. This includes evaluations, progress reports, assessments, or psychological test reports.
3. You have the right to know the name and credentials of any supervisor and how to contact him/her. The psychology resident will share this information with you at your request at any time.
4. Because of the training mission of MCARPT, the psychology resident may ask your permission to record sessions for confidential supervisory or training purposes. Occasionally, such tapes may be presented in case conferences or group supervision for MCARPT trainees and supervisors. You have the right to refuse such requests and this will have no bearing on the service delivery of the psychology resident to your case.
5. Although psychology residents have earned a doctoral degree in clinical or counseling psychology, they are not yet licensed to practice independently. All clinical work done by the resident is reviewed by one or more supervising licensed psychologists. Your identifying information will be available to this supervisor in the course of professional staffing between the resident and the supervisor.
6. Both the psychology resident and his/her clinical supervisors are governed by the Ethical Principles of Psychologists and Code of Conduct (2002) of the American Psychological Association (<http://www.apa.org/ethics>). Further, psychologist supervisors are bound by the rules and statutes of the Minnesota Board of Psychology (<http://www.psychologyboard.state.mn.us/>).
7. Psychology residents may discuss your case with other trainees in the MCARPT program in the service of training and case consultation. In those cases, anonymity is assured and any identifying information will be protected.
8. You have the right to discontinue treatment with the psychology resident at any time. In such cases, you will be provided alternate treatment resources in the community.
9. There are no fees associated with direct service provided by unlicensed psychology trainees. However, some trainees may qualify for licensure and obtain independent practitioner status while still completing the residency. You or your insurance

company MAY be charged for face to face psychological services under those circumstances. The trainee will make any fees explicitly clear to you prior to initiating services.

10. The content of your professional sessions with the psychology resident are strictly confidential. However, under the following circumstances, information will be released:
 - A. Information will routinely be shared with the resident’s clinical supervisor(s) for purposes of supervision, training, and education.
 - B. Information may be shared in group supervision with other residents and professional staff but your identifying information will be withheld.
 - C. With your prior written consent, information can be released to other providers or professionals.
 - D. Suspicion of child abuse or neglect or abuse of vulnerable adults will be reported in accordance with Minnesota Statutes, section 635.556 (1990).
 - E. Court orders and subpoenas will be responded to in keeping with state and local requirements and ethical standards of disclosure.
 - F. If in the professional judgment of the psychology resident and his/her clinical supervisor, you are in imminent and clear danger to yourself or others, there exists a legal mandate to inform proper authorities in order to protect you or others from harm.
 - G. If during the course of psychological services the psychology resident and his/her supervisor learns or has reason to believe that a woman is pregnant and has used a controlled substance for nonmedical purposes during the pregnancy, Minnesota law requires that a report be made to local social service agencies.
 - H. In its 2004 session, the Minnesota Legislature clarified that a health care provider must provide mental health information about a patient/client to a law enforcement agency, “if the law enforcement agency provides the name of the patient and communicates that the: (1) patient is currently involved in an emergency interaction with the law enforcement agency; and (2) disclosure of the records is necessary to protect the health or safety of the patient or another person. The scope of the disclosure is limited to the minimum necessary for law enforcement to respond to the emergency (Minnesota Statute, section 144.335).

I have read the above guidelines and am requesting psychological services in accordance with this policy.

Date

Patient signature

Patient name (print)

Signature of Parent/Guardian

Weekly Accrued Fellowship Hours MCARPT

During the week of _____

Type of Activity	Total Number of Hours
Intake Evaluations	_____
Assessments/Psychological Testing	_____
Individual Psychotherapy/Counseling	_____
Group Psychotherapy/Counseling	_____
Community Interventions	_____
Research	_____
Teaching/Psychoeducational	_____
Consultation	_____
Record Keeping/Case Management	_____
Driving Time	_____
Supervision (Group/Individual)	_____
Education (CME, Seminars, etc.)	_____
Other (specify _____)	_____
Total Hours	_____

Resident Signature: _____

Date: _____

Resident Name: _____

Supervisor Signature: _____

Date: _____

Supervisor Name: _____

Supervision Contract
Minnesota Consortium for Advanced Rural Psychology Training (MCARPT)

Contract Date:

Expires:

Supervisor:

Supervisee:

This contract serves as description and verification of the clinical supervision provided by _____ to _____ as part of the guidelines for training in the MCARPT post-doctoral residency program.

A. Purpose, Goals, and Objectives

- i. Meet the clinical needs of clients served by MCARPT psychology residents
- ii. Ensure sound professional and ethical practice in accordance with the APA 2002 *Ethical Principles of Psychologists and Code of Conduct* and rules promulgated by the Minnesota Board of Psychology's *Psychology Practice Act*.
- iii. Promote professional growth in psychology residents and ensure the acquisition of solid clinical, professional, interpersonal, and intrapersonal growth towards independent practice.

B. Context of Supervision

- a. Individual Supervision
 - i. Location: _____
 - ii. Time: _____
 - iii. Duration: _____
 - iv. Frequency: _____
- b. Group Supervision
 - i. Location: _____
 - ii. Time: _____
 - iii. Duration: _____
 - iv. Frequency: _____
 - v. Facilitator: _____

C. Method of Evaluation

- a. Feedback will be provided weekly in verbal and/or written format at both individual and group supervision.
- b. Quarterly performance evaluations will be conducted by MCARPT site faculty every 3 months and also at the end of the training year. More frequent evaluations, both verbal and written, will be conducted as necessary to ensure fulfillment of the training goals.
- c. Supervisees will also evaluate each site supervisor and placement on a quarterly basis.

- d. Copies of specific evaluation forms are to be found in the MCARPT training manual.

D. Duties

- a. Supervisee (psychology resident)
 - i. The resident will familiarize him/herself with all policies and procedures of MCARPT consortium sites and follow such at all times when on site for training.
 - ii. The resident will follow APA ethical standards (2002) and conduct him/herself with professional demeanor and respect at all times.
 - iii. The resident will attend all individual and group supervision meetings unless prior approval from the Director of Training is obtained.
 - iv. The resident will utilize empirically supported treatment modalities or other interventions considered to be within the standard of care for professional psychology.
 - v. The resident will bring information to supervision and be prepared to present case conceptualization and treatment plan when requested.
 - vi. The resident will implement supervisor's directives from previous supervisory meetings.
 - vii. The resident will consult with appropriate supervisors as needed in crisis or emergency situations or any time that scope of competence is a concern.
 - viii. The resident will obtain co-signatures, in hard copy or electronically, from the supervisor, or his/her designee, on all documentation and correspondence.
- b. Supervisor
 - i. The supervisor will ensure that ethical and professional guidelines and standards are upheld at all times.
 - ii. The supervisor will attend all scheduled supervisory meetings unless prior notification is provided to supervisees. Every attempt will be made to provide alternative supervisory coverage.
 - iii. The supervisor will examine all of the resident's clinical records and documentation and sign off on all resident work.
 - iv. The supervisor will assess resident's progress towards professional goals and objectives and monitor supervisee's clinical and professional skills.
 - v. The supervisor will support the resident's development as a professional psychologist.
 - vi. The supervisor will align supervisory practice to conform with requirements for licensure as a psychologist in the state of Minnesota.
 - vii. The supervisor will intervene when client welfare is at risk.

E. Procedural Considerations

- a. Supervisory meetings will consist of some or all of the following:
 - i. Review of directives.

- ii. Review of goals/objectives for supervision
- iii. Case presentations.
- iv. Documentation/administrative review.
- v. Professional development issues.
- vi. Questions/answers
- vii. Supervisor directives.

In case of an emergency, the resident will contact the supervisor at:

Work #: _____

Cell #: _____

Home #: _____

F. Supervisor's Scope of Competence

Dr. Jeff Leichter is a licensed psychologist with MeritCare Health System in Detroit Lakes, MN. He received his PHD in clinical psychology from the California School of Professional Psychology/Alliant University, in Los Angeles in 1987. He then completed a 2 year postdoctoral fellowship in primary care health psychology at Michigan State University Department of Family Medicine in 1989. Since 1990 he has been employed as a staff psychologist at the MeritCare clinic in Detroit Lakes, and maintains a psychology practice there serving adults and adolescents. He is licensed as a psychologist in Minnesota, Arizona, and Michigan and holds the Certificate of Professional Qualification in psychology issued by the Association of State and Provincial Psychology Boards and is a registrant of the National Register of Health Service Providers in Psychology. He is a member of the American Psychological Association, Arizona Psychological Association, and Minnesota Psychological Association where he has served twice on the executive council. He was a consulting editor for the journal, *Professional Psychology: Research and Practice* from 2001-2006.

G. Terms of the Contract

This contract is subject to revision at any time, upon request of the supervisee or supervisor. A formal review of the contract is made at the 6 month review.

We agree, to the best of our ability, to uphold the directives specified in this supervision contract and to conduct our professional behavior according to the Ethical Principles and Code of Conduct (2002) of the American Psychological Association.

Supervisor: _____ Date: _____

Supervisee: _____ Date: _____

This contract is effective from _____ to _____