

**VA Maryland Health Care System/
University of Maryland School of Medicine
Psychology Internship Consortium**



**The VAMHCS/UM SOM Psychology Internship Consortium
is accredited by the
American Psychological Association**

The next site visit will be during the 2023 training year.

Questions related to the program's accreditation status should be directed to the
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INTRODUCTION

Clinical Settings

VA Maryland Health Care System

The Veterans Affairs Maryland Health Care System (VAMHCS) is a dynamic and progressive health care organization dedicated to providing quality, compassionate and accessible care and service to Maryland's Veterans. The Baltimore and Perry Point VA Medical Centers, in addition to the Loch Raven VA Community Living & Rehabilitation Center and six community based outpatient clinics, all work together to form this comprehensive health care delivery system. Nationally recognized for its outstanding patient safety and state-of-the-art technology, the VAMHCS is proud of its reputation as a leader in Veterans' health care, research and education.

Statistics for FY 2014 show that the VAMHCS recorded almost 600,000 separate outpatient encounters, with over 52,000 unique patients. The Baltimore VA Medical Center recorded almost 400,000 separate patient encounters with over 45,000 unique patients, and the Perry Point Medical Center recorded almost 100,000 and over 13,000 unique patients for the same time period. The sheer volume of patients treated across the variety of clinics ensures that interns are exposed to a diversity of patient demographics, encounter a spectrum of degrees of complexity in presenting mental health and medical problems, and experience a variety of patient problems with enough frequency to establish good baseline knowledge of a variety of psychological phenomena.

Baltimore VA Medical Center: The Baltimore VA Medical Center is located in a vibrant city neighborhood on the campus of the University of Maryland at Baltimore (UMB) and is within walking distance of Oriole Park at Camden Yards, M&T Bank Stadium, Lexington Market and the Inner Harbor. The Baltimore VA Medical Center is the acute medical and surgical care facility for the VAMHCS and offers a full range of inpatient, outpatient and primary care services, as well as a number of specialized programs and services, including integrated mental health in primary care programs, a women Veterans evaluation and treatment program, medical psychology and treatment for chronic pain, inpatient and outpatient mental health care services, a residential trauma recovery program, and an intensive outpatient substance abuse detoxification and treatment program. Three blocks from the medical center, the Baltimore Annex offers outpatient mental health programming in the following specialty areas: trauma recovery, neuropsychology, and psychosocial rehabilitation and recovery.

Perry Point VA Medical Center: The Perry Point VA Medical Center is located about 45 minutes north of Baltimore on a beautiful campus of approximately 400 acres on the banks of the Susquehanna River and the Chesapeake Bay. It provides a broad range of inpatient, outpatient, and primary care services and is a leader in providing comprehensive mental health care to Maryland's Veterans. The medical center offers long and short-term inpatient and outpatient mental health care, including the following specialized treatment programs:

- Mental Health Intensive Case Management
- Psychosocial Rehabilitation and Recovery Center
- Health Improvement Program
- Family Intervention Team
- Outpatient Trauma & Post Traumatic Stress Disorder Program
- Substance Abuse Residential Rehabilitation Treatment
- Domiciliary Residential Rehabilitation Treatment (for Homeless Veterans)

Loch Raven Community Living & Rehabilitation Center: The Loch Raven VA Community Living & Rehabilitation Center specializes in providing rehabilitation and post-acute care for patients in the VAMHCS. The center coordinates the delivery of rehabilitation services, including physical therapy, occupational therapy, kinesiotherapy and recreation therapy, to achieve the highest level of recovery and independence for Maryland's

Veterans. The center also provides hospice and nursing home care to Veterans requiring non-acute inpatient care, in addition to offering specialized treatment for patients with Alzheimer's disease and other forms of dementia.

Community Based Outpatient Clinics (CBOCs): Each of our 6 CBOCs provide primary care and limited specialty medical care services. Every CBOC offers Primary Care-Mental Health Integration (PC-MHI), telemental health services, as well as specialty mental health services. Some of the larger CBOCs provide PTSD and Substance Use Disorder services.

- Cambridge VA Outpatient Clinic
- Fort Howard VA Outpatient Clinic
- Fort Meade VA Outpatient Clinic
- Glen Burnie VA Outpatient Clinic
- Loch Raven VA Outpatient Clinic
- Pocomoke City VA Outpatient Clinic

University of Maryland School of Medicine- University of Maryland Medical Center

Founded in 1823 as the Baltimore Infirmary, the University of Maryland Medical Center (UMMC) is one of the nation's oldest academic medical centers. Located on the west side of downtown Baltimore, the Medical Center is distinguished by discovery-driven tertiary and quaternary care for the entire state and region and innovative, highly specialized clinical programs. The University of Maryland School of Medicine (UM SOM) is housed on the UMMC campus which is part of the University of Maryland Medical System (UMMS), a network of nine area hospitals: University of Maryland Medical Center, UMMC Midtown Campus, Mt. Washington Pediatric Hospital, UM Baltimore Washington Medical Center, UM Charles Regional Medical Center, University of Maryland Rehabilitation and Orthopedic Institute, UM St. Joseph Medical Center, UM Shore Regional Health, and UM Upper Chesapeake Health.

Patients admitted to the UMMC benefit from the talent and experience of the very finest physicians, nurses, researchers and other health care providers. Here, health care professionals from many disciplines work together as a team to cure illness, conquer disease, and assure the needed support for patient and family alike. All of the medical center's physicians are faculty members at the School of Medicine, the nation's fifth oldest and first public medical school and a recognized leader in biomedical research and medical education.

Clinical and Research Innovation

VAMHCS/UM SOM Consortium interns are exposed to clinical and research experiences within a number of centers. Having several robust research programs enhances the ability to provide state-of-the-art medical techniques and treatments while providing high quality scientist-practitioner training to Consortium interns.

The VAMHCS is home to the following specialized clinical and research centers:

1. *Epilepsy Center of Excellence* – focus on improving the health and well-being of Veteran patients with epilepsy and other seizure disorders through the integration of clinical care, outreach, research, and education
2. *Geriatric Research, Education and Clinical Center (GRECC)*- focus on promoting health and enablement models in older Veterans living with disability
3. *Maryland Exercise and Robotics Center of Excellence (MERCE)*- focus on rehabilitation of individuals with chronic deficits as a result of stroke with additional developing programs in Parkinson's Disease, Multiple Sclerosis, Chronic Pain, and Traumatic Brain Injury
4. *Mental Illness Research, Education and Clinical Center* – focus on supporting and enhancing the recovery and community functioning of Veterans with serious mental illness through research, education, clinical training and consultation

5. *Multiple Sclerosis (MS) Center of Excellence – East (MSCoE East)* – focus on understanding multiple sclerosis, its impact on Veterans, and effective treatments to help manage multiple sclerosis symptoms

UM SOM boasts several research centers:

1. *Division of Services Research (DSR)* – focus on conducting research that improves the quality and outcomes of care for persons suffering from mental disorders
2. *Center for School Mental Health (CSMH)* – focus on strengthening policies and programs in school mental health by advancing evidence-based care in schools and collaborating at local, state, national, and international levels to advance research, training, policy, and practice in school mental health
3. *Maryland Psychiatric Research Center (MPRC)*- focus on providing treatment to patients with schizophrenia and related disorders, educating professionals and consumers about schizophrenia, and conducting basic and translational research into the manifestations, causes, and treatment of schizophrenia
4. *Center for Behavioral Treatment of Schizophrenia (CBTS)* – focus on developing and evaluating behavioral treatments for schizophrenia and the integration of psychosocial and pharmacological treatments
5. *Taghi Modarressi Center for Infant Study (CIS)* – focus on providing multidisciplinary care in an outpatient setting for children ages 0-6 with emotional and behavioral concerns and studying the relationship between social competence and behavior problems, parenting factors and parenting stress, and routines and other related behaviors in preschool children
6. *General Clinical Research Center* - cornerstone for clinical research within the University of Maryland by providing supports the full spectrum of patient-oriented research
7. *UM School of Medicine Clinical and Translational Sciences Institute* - focus on providing a portal for high-quality cost-effective resources and services for clinical and translational researchers that will support clinical research, informatics, biostatistics, genomics and other core services, community engagement ethics and regulatory science, pilot projects and the development of novel technologies fully integrated through a shared organizational structure and wired by informatics
8. *UM Child and Adolescent Mental Health Innovations Center* – focus on developing and advancing evidence-based interventions for community mental health treatment, models for integration of behavioral health services, and multi-disciplinary training to improve services for underserved young people

PROGRAM OVERVIEW

Training Model and Program Philosophy

The VAMHCS/UM SOM Psychology Internship Consortium adheres to the scientist-practitioner approach to training. The Consortium applies this model by grounding the content and process of training in research, with the purpose of developing well-rounded and competent psychologists. Studies of methods of training have consistently demonstrated processes for effectively impacting trainee behavior, which include modeling desired behaviors, providing opportunities to practice those behaviors in a supervised environment, and giving specific feedback on progress toward the desired behavior. Utilizing this approach, within a developmental framework of continuous reciprocal trainee feedback and program evaluation, the Consortium can meet the individualized goals of each trainee while enhancing progress toward core training competencies.

Our program believes that evidence-based practice for the psychological treatment of mental illness and other conditions are crucial for the effective care of patients. We require our interns to actively engage in research that supports their ability to: 1.) identify and clearly describe the disorders and conditions presented by patients, 2.)

select or create reliable and valid outcome measures that are sensitive to changes in patients' disorders or conditions, and 3.) identify and successfully administer treatments to improve these disorders or conditions.

As one of the few internship training programs recognized by the Academy of Psychological Clinical Science (APCS), the Consortium is particularly interested in applicants from graduate programs that place an equally strong emphasis on scientific study and broad clinical training. For the scientist component, it is expected that applicants have a combination of peer-reviewed publications and professional presentations that clearly demonstrate their skills as a psychological scientist. For the practitioner component, it is expected that applicants have solid foundational training and skills across a broad range of clinical populations, evidence-based practices, and in a wide range of objective psychological assessments. Each of these requisite skills must be clearly addressed in the application and in letters of recommendation.

While adhering to a scientist-practitioner approach to training that underscores evidence-based practice, the Consortium aims to train and refine skills in core competency domains with the ultimate goal of facilitating the development of interns from trainees to independent psychologists. As an illustration, specific training in assessment or treatment for a particular presenting problem will be grounded in research, clinical practice guidelines, and expert consensus on that problem. In addition, to foster interns' development as independent scientist-practitioners, didactics and supervision will focus on the skills needed to function independently as a psychologist in a multidisciplinary hospital setting.

To round out existing scientific and clinical skills, extensive efforts are made to tailor the internship training experience to each individual intern's needs and allow a reasonable amount of focused specialization in each intern's area of emphasis. For example, psychology interns attend a weekly didactic seminar that is focused on general training in core competency domains. In addition, interns in specialty tracks attend seminars focused on their area of specialty. Graduates of our program may pursue careers in research or clinical service, but in either case, their training will have prepared them to make a meaningful contribution to the effective care of patients.

Role of the Staff

Consortium staff and supervisors are held to the highest levels of professional and ethical conduct. They are expected to both model these behaviors and promote intern engagement in the following: 1.) ethical and responsible clinical and scientific conduct, 2.) participation in self-regulatory and professional review activities, 3.) commitment to continued professional self-development through participation in training and educational activities, and 4.) activities promoting professional autonomy, such as active involvement with local, state, and national organizations, legislative efforts, and licensure activities.

Role of the Intern

Consortium interns are expected to assume the role of professional psychologist within their training assignments. This role requires awareness of and adherence to the highest principles of professional ethics, conduct, and competence, as well as a sincere interest in the welfare of clients. Interns have the opportunity to learn new clinical skills and techniques from their supervisors and other staff, as well as the opportunity to improve and modify existing skills. The majority of an intern's time is focused on expansion of clinical competencies. Though interns are expected to conduct themselves professionally, their tasks are primarily learning-oriented. Although there is some variability across training sites and specific clinical rotations, clinical service delivery is considered incidental to the learning process. Interns are not expected to assume the same quantity of duties, workload, or responsibilities normally assigned to the professional psychology staff.

Expectations

Interns are expected to be involved in their clinical training assignments to the benefit of the VAMHCS and UMB health care delivery systems and their own learning experiences. They are expected to participate in training meetings and to present material in case presentations, seminars, and other formats during the year, and to engage willingly in dialogue with staff in the service of professional training and development. Interns are expected to adhere to the ethical guidelines established for psychologists by the American Psychological Association and to the policies and procedures of their host institution and clinics.

Training Goals and Objectives

Along with adherence to a scientist-practitioner training model, the Consortium aims to develop and refine skills in eight core competency domains, which are deemed essential in facilitating the development of interns from trainees to independent psychologists. From these eight core domains, corresponding goals are generated and outlined below in Table 1: Consortium Competencies and Goals.

Table 1: Consortium Competencies and Goals

Competency	Goal
1. Professional Values, Attitudes, and Behaviors	Demonstrate a commitment to the professional values and attitudes symbolic of a health service psychologist.
2. Ethics and Legal Matters	Demonstrate an ability to think critically about ethical and legal matters as they pertain to the professional practice of psychology. Demonstrate increasing competence identifying and addressing ethical and legal matters, as required or suggested by the APA guidelines, state laws, or institutional policies.
3. PROFESSIONAL COMMUNICATION, CONSULTATION AND INTERPERSONAL SKILLS	Demonstrate the ability to effectively communicate with teams of providers, staff, and other stake holders as it relates to duties performed within the scope of professional psychology. Able to seek out consultation when needed and provide consultation to others in intern's area of expertise.
4. INDIVIDUAL AND CULTURAL DIVERSITY	Demonstrate an ability to think critically about pertinent cultural and/or other individual differences that might impact the patient's presenting problem or his or her ability to engage in treatment/assessment.
5. THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT	Demonstrate an ability to produce thorough and meaningful integrated psychological assessment reports and communicate those findings effectively to patients and others (e.g., other providers, families, etc.)
6. THEORIES AND METHODS OF EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION	Demonstrate the ability to consistently and effectively engage and collaboratively develop therapy goals with patients with a wide range of presenting problems. Effectively selects, tailors and delivers appropriate evidence based (or where appropriate, evidence informed) interventions.
7. SCHOLARLY INQUIRY AND APPLICATION OF CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE	Demonstrate the initiative and ability to integrate scientific knowledge into professional clinical practice.
8. CLINICAL SUPERVISION	Demonstrate an understanding of supervision theory and practice. Able to apply supervision principles to self under the guidance of a licensed psychologist. Ability to provide supervision to others when such activities are available in specific clinical settings.

Evaluation Procedures

Multiple methods are used to evaluate the Consortium training model and intern progress with the eight identified training competencies (Table 2: Consortium Evaluation Plan). Interns are monitored throughout the year, with the aim of facilitating developmental learning and progress toward the eight core competency domains. In

In addition to measuring progress with these core domains, evaluations include measurement of rotation-specific competencies and open-ended qualitative feedback. A sample evaluation form can be found in Appendix A. It is expected that all items be rated at the basic competency level (i.e., internship entry level with close supervision needed) or higher at mid-rotation for VA Interns and mid-year for UMB interns. By the end of the rotation or the training year, for VA and UMB interns respectively, it is expected that all items be rated, minimally, at the intermediate competency level (i.e., routine supervision needed).

Table 2: Consortium Evaluation Plan

Evaluation Type	Competency	Time Point	Scale
Trainee Core Competency	1. Professional values, attitudes, and behaviors	VA: Each rotation Initial and Final (6)	1 - Below entry level 2- Basic competency/entry level 3- Intermediate 4- Intermediate to Advanced 5- Advanced/autonomous practice
	2. Ethics and legal matters		
	3. Professional communication, consultation, and interpersonal skills	UM: Oct, Feb, June (3)	
	4. Individual and cultural diversity		
	5. Theories and methods of psychological diagnosis and assessment		
	6. Theories and methods of psychotherapeutic intervention		
	7. Scholarly inquiry and application of scientific knowledge to practice		
	8. Clinical supervision		
Trainee Self-Assessment	1. Professional values, attitudes, and behaviors	Initial and Final (2)	1 - Below entry level 2- Basic competency/entry level 3- Intermediate 4- Intermediate to Advanced 5- Advanced/autonomous practice
	2. Ethics and legal matters		
	3. Professional communication, consultation, and interpersonal skills		
	4. Individual and cultural diversity		
	5. Theories and methods of psychological diagnosis and assessment		
	6. Theories and methods of psychotherapeutic intervention		
	7. Scholarly inquiry and application of scientific knowledge to practice		
	8. Clinical supervision		
Research and Minor Rotations	As Applicable:	Mid and Final (2)	1 - Below entry level 2- Basic competency/entry level 3- Intermediate 4- Intermediate to Advanced 5- Advanced/autonomous practice
	1. Professional values, attitudes, and behaviors		
	2. Ethics and legal matters		
	3. Professional communication, consultation, and interpersonal skills		
	4. Individual and cultural diversity		
	5. Theories and methods of psychological diagnosis and assessment		
	6. Theories and methods of psychotherapeutic intervention		
	7. Scholarly inquiry and application of scientific knowledge to practice		
8. Clinical supervision			
Supervision	1. Supervisory Responsibilities	VA: Each rotation Mid and Final (6)	Likert: 1-5 and N/A From Very Ineffective to Very Effective
	2. Supervisory Content		
	3. Supervisory Process	UM: Oct, Feb, June (3)	
	4. Assistance in Professional Development		
	5. Assistance in Development as Scientist-Practitioner		
	6. Assistance in Meeting Training Goals	All: Mid and Final Research and Minor	
	7. Summary Ratings		
Year-End	1. Rotation Specific	End of Year (June)	Qualitative Confidential
	2. General Questions		
	3. Seminar		

If the supervisor perceives that there is a significant deficiency in the intern’s competency, the supervisor is to complete the evaluation form at the time the deficiency is identified (even if this occurs outside of the designated evaluation time points) and review it with the intern and the Training Director so that remediation can begin

expeditiously. Criteria for successful completion of the training year include completion of all training rotations, completion of six comprehensive integrative assessment reports, completion of a research project, and attendance in weekly didactic training. The Training Director maintains communication with the interns' graduate programs by providing a letter at the beginning of the year, which describes each intern's training plan, a letter mid-way through the year, which describes each intern's progress with the training plan, and a letter of internship completion at the end of the training year.

Although rotation supervisors provide formal evaluations of intern progress meeting training goals, interns are also asked to provide a self-assessment of these core competency domains at the beginning of the training year and at the end of the training year. Although this self-assessment is not factored into the formal rating of an intern, it is an important aspect of the training program. The self-assessment is discussed individually with the Training Director and is also provided to rotation supervisors as another opportunity to facilitate individualized training and core competency development.

During each evaluation time point, interns provide evaluations of rotation supervisors within the following domains: supervisory responsibilities, supervisory content, supervisory process, assistance in professional development, assistance in development as a scientist-practitioner, assistance in meeting training program core competencies, and assistance in meeting training goals. Interns are encouraged to use these evaluations as an additional opportunity to discuss how supervisors can assist with meeting training goals and expectations. The Training Director also receives a copy of these evaluations.

Last, interns provide confidential qualitative program-level feedback to the Training Director at the end of the training year. Interns are queried on the following experiences: clinical rotations, general strengths and weaknesses of the Consortium, didactic training, and the research requirement. Once de-identified and aggregated, this feedback is shared with the Training Committee to inform program improvements.

Clinical Supervision and Support

Interns receive a minimum of four hours per week of supervision, at least two hours of which are individual, face-to-face supervision with a licensed psychologist. Supervisors are readily available to respond to interns' questions and provide impromptu guidance. When an intern's primary supervisor is on leave, back-up coverage is clearly delineated. At the beginning of a training rotation, the supervisor and intern jointly assess the intern's training needs and establish individualized training goals. Over the course of the rotation, the intern is expected to become more independent in his or her activities, consistent with the Consortium's developmental approach to training. As this process of attaining graduated levels of responsibility unfolds, the supervision becomes less directive and more consultative.

Staff psychologists with appropriate clinical privileges provide primary supervision to interns. Credentialed clinicians from allied professions and non-staff psychology consultants provide supplemental training expertise. There are opportunities for additional supervisory consultation with psychologists working outside the intern's normal assignment area as well. Consortium faculty use various modes and models of supervision in the training of interns, including co-therapy, analysis of audiotaped or videotaped sessions, supervisor "shadowing," and "junior colleague." In all cases, interns work closely with supervisors initially, and then gradually function more independently as their skills develop. Responsibility for ensuring adequacy of supervision rests with the Consortium Training Committee, under the leadership of the Psychology Training Program Director.

The Consortium Training Committee believes that evidence-based best practice guidelines for the psychological treatment of mental illness and other conditions are crucial to the effective care of patients. Consortium supervisors are trained in a number of theoretical orientations and value the use of scientific literature to inform clinical practice. The Consortium Training Committee also believes that evidence-based practice requires that psychologists maintain the skills to interpret relevant research findings and treatment developments, as well as the skills to contribute to this expanding knowledge base.

In addition to formal supervisory relationships, Consortium interns may take advantage of a mentorship program that pairs interns with a non-supervisor mentor to assist with growth in professional development. The nature of this relationship can be defined and structured as necessary for each trainee. Areas that have been of focus include defining one's professional identity, postdoctoral fellowship and job applications/interviewing strategies,

assistance with grant-writing and publications, and managing grievances. Additionally, each internship cohort is offered the opportunity to participate in a consultation group facilitated by a psychologist in a non-supervisory role. The group typically meets twice per month to provide support and encouragement regarding dissertation progress, supervision, adjustment to internship, living in a new city, and professional development. Finally, the Training Committee meets once per month with the internship class to discuss current concerns as well as topics related to professional development.

Training Term

The internship training year is for a term of 12-months beginning on or about June 30th. Interns must work at least 2,080 hours, with most interns working an average of 40-50 hours per week. This length is consistent with the majority of other psychology internships in the United States and allows interns to meet state licensure requirements. Interns spend approximately 24 hours per week engaged in clinical activities at their major rotation/clinic. The remaining 16 hours include minor clinical rotations (up to 6 hours per week), a research minor rotation (up to 6 hours per week), seminars (3 or more hours per week), and administrative activities.

Stipend and Benefits

The current intern stipend is \$29,080. Interns accrue 4 hours bi-weekly of annual leave (13 days total), 4 hours bi-weekly of sick leave (13 days total), 10 federal holidays, and up to 5 professional development days to attend conferences, present papers, or to defend their dissertations. Interns at both the VAMHCS and UMB have access to the health insurance coverage at their respective institutions. There is good public transportation to the Baltimore VA Medical Center and the UMB campus, and interns can utilize a transit reimbursement program if they choose to use public transportation. Parking is not provided, but is available downtown in for-pay parking garages.

TRAINING TRACKS

The Consortium offers training tracks in the following areas: comprehensive/general, health psychology, neuropsychology, serious mental illness, trauma recovery, outpatient psychiatry/integrated health, child outpatient, and school mental health. Interns who match to each track are provided with an organized training plan that includes year-long clinical training through rotation selection, minor rotations, research projects, and a didactic seminar series in their area. Please refer to Table 3: Consortium Track Requirements for an overview of track-specific training requirements.

VAMHCS-based Training Tracks

VA-based interns will have the opportunity to prioritize their preferences for rotation assignments at the beginning of the training year. A listing of typical rotation offerings is provided in Table 4: Rotations by Site. These rotations are offered on a regular basis and are generally available each training year. However, there may be times when staffing issues require cancellation of a rotation without advance notice. To ensure an optimal training experience, the number of interns that can be assigned to each rotation is limited; therefore, it is not always possible for every intern to do all of their preferred rotations. The Training Director works with each intern upon their arrival to determine the best possible selection and scheduling of rotations.

Interns in the VA-based training tracks (Comprehensive, Neuropsychology, PTSD/Trauma Recovery, Health Psychology and Serious Mental Illness) complete three four-month major rotations during the year, which are based at VA facilities, with some opportunities for minor clinical rotations or research activities based at the School of Medicine. VA interns are expected to complete rotations at more than one VA facility throughout the training year (i.e., Baltimore, Perry Point, and Loch Raven). VA interns select rotation experiences based on their interest, availability, and institutional need.

Table 3: Consortium Track Requirements

Track	Number of Rotations Required Within Track	Minor Required Within Track	Research Required Within Track	Required
VA Comprehensive	Not Applicable	Not Applicable	Not Applicable	Not
VA Health	2	Not Required	Not Required	
VA Neuropsychology	2	Yes	Available, Encouraged	
VA Serious Mental Illness	2	Not Required	Available, Encouraged	
UM Serious Mental Illness	Full Year	Not Required	Available, Encouraged	
VA Trauma Recovery	2	Available, Not Required	Available, Not Required	
UM Trauma Recovery	Full Year	Not Required	Not Required	
UM Clinical High Risk for Psychosis	Full Year	Not Required	Yes	
UM School Mental Health	Full Year	Not Applicable	Yes	

Table 4: Rotations by Site

Site	Typical Rotations Offered
University of Maryland	School Mental Health
	Child Outpatient (not offered 2019-2020)
	Clinical High Risk for Psychosis (serving ages 12-25)
	Outpatient Psychiatry/Integrated Health
	Serious Mental Illness (not offered 2019-2020)
Baltimore VA Medical Center	Neurology/Chronic Pain
	Health Psychology
	Dual Diagnosis (Outpatient Substance Use Treatment Program)
	Intensive Outpatient Substance Use Treatment Program (ACT)
	Primary Care – Mental Health Integration
Baltimore VA Annex	Neuropsychology
	Outpatient Trauma Recovery Program/ Returning Veterans Engagement Trauma Services
	Psychosocial Recovery and Rehabilitation Center
Perry Point VA Medical Center	Geropsychology – Community Living Center
	Mental Health Clinic
	Psychosocial Recovery and Rehabilitation Center
	Residential Treatment: SMI, Domiciliary, and/or Addictions
	Primary Care – Mental Health Integration

	Geropsychology – inpatient/outpatient
Loch Raven	Palliative Care
	Primary Care – Mental Health Integration

VA Comprehensive Track

Comprehensive Track interns complete three four-month rotations from any of the comprehensive list of available rotations (beginning on page 20). Examples of former Comprehensive interns’ research projects have included:

- Assessing Self-as-context in the ACT IOP
- Racial Differences in Mental Health Recovery Orientation Among Veterans with Serious Mental Illness
- Smoking Norms Among Individuals with Serious Mental Illness

VA Health Psychology Track

Health Psychology interns complete two of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

- Neurology (Baltimore)
- Primary Care – Mental Health Integration (Baltimore)
- Primary Care – Mental Health Integration (Perry Point)
- Hospice/Palliative Care (Loch Raven)

In addition to the Consortium didactics seminar, Health Psychology interns participate in a monthly didactic seminar focused on advanced topics in Health Psychology assessment, intervention, and consultation. Topics are presented by the core Health Psychology staff, but the didactic is meant to stimulate thoughtful conversation about a variety of topics of interest to the interns.

Examples of former Health Psychology interns’ research projects have included:

- The Effects of Health Behavior Motivation on Exercise and Autonomic, Cognitive, and affective Function Post Stroke
- Health Perceptions, Behaviors, and Coping in Veterans with Insulin Resistance or Type 2 Diabetes Completing an Exercise Intervention.

VA Neuropsychology Track

Consistent with Houston Guidelines, Neuropsychology Track interns spend a minimum of 50% of their training year involved in clinical, didactic, and research endeavors within neuropsychology. Interns in the Neuropsychology track are expected to complete two major rotations in Neuropsychology at the Baltimore VA Medical Center/Annex Building as well as a year-long minor rotation in Neuropsychology. Additionally, the intern may choose one major rotation of their choice. Training activities include outpatient and inpatient consultation as well as interdisciplinary assessment. Additionally, interns receive training in cognitive

rehabilitation. Example training settings include Dementia Clinic, Cognitive Rehabilitation Clinic and general outpatient clinics.

In addition to patient specific supervision and the Consortium didactics seminar, neuropsychology interns participate in the following neuropsychology didactics and activities at various intervals:

Required

1) *Neuropsychology AM Report*

- a. Every Monday & Wednesday
- b. Time: 8:30 AM -9:00 AM
- c. Location: Neuropsychology conference room, 5th floor Annex
- d. Description:
 - i. Interns present cases to be seen that day or in following days
 - ii. Review approach to assessment and corresponding rationale

2) *Neuropsychology Case Conference*

- a. Every Tuesday
- b. Time: 2:30 PM-3:30 PM
- c. Location: Neuropsychology conference room, 5th floor Annex
- d. Description:
 - i. All interns rotate presenting cases
 - ii. Faculty occasionally present cases
 - iii. Practice fact-findings are conducted
 - iv. Report critiques are also periodically conducted

3) *Neuropsychology Fellowship Video Teleconference*

- a. Every Thursday
- b. Time: 1:00 PM-3:00 PM
- c. Location: Neuropsychology conference room, 5th floor Annex
- d. Description:
 - i. Participating sites are Baltimore VAMC, Brooke Army Medical Center, National Rehabilitation Hospital, Tripler Army Medical Center, Walter Reed Army Medical Center, Washington DC VAMC
 - ii. First hour – case conference, fellows rotate presenting cases
 - iii. Second hour – presentation and discussion of assigned readings
 - iv. Purpose is to prepare fellows for board certification in clinical neuropsychology
 - v. Fellows actively participate, interns attend and complete assigned readings

4) *Neuropsychology Treatment Group Supervision*

- a. Every Tuesday
- b. Time: 2:00 PM-2:30 PM
- c. Location: Neuropsychology conference room, 5th floor Annex
- d. Description:
 - i. Ongoing cognitive rehabilitation and psychotherapy cases discussed
 - ii. Didactic material presented by staff and fellows

5) *Neuropsychology Dementia Clinic Group Supervision*

- a. Every other Thursday
- b. Time: 3:00 PM-4:00 PM
- c. Location: Neuropsychology conference room, 5th floor Annex
 - i. Patients seen in Tuesday and Friday dementia clinics are discussed

- ii. Didactic material presented by staff and fellows
- 6) *Neuropsychology Journal Club*
- a. 1st Thursday of each month
 - b. Time: 3:00-4:00 PM
 - c. Location: Neuropsychology conference room, 5th floor Annex
 - d. Description:
 - i. Faculty/interns rotate selecting an article and leading the discussion
 - ii. Review 1 empirical article relating to neuropsychology each meeting
 - iii. Discuss methodological approach, results, and relevance to ongoing clinical work and research endeavors

Additional Training Opportunities

- 1) *Neuropsychology Fellowship Video Teleconference*
- a. Every Thursday
 - b. Time: 1:00 PM-3:00 PM
 - c. Location: Neuropsychology conference room, 5th floor Annex
 - d. Description:
 - i. Participating sites are Baltimore VAMC, Brooke Army Medical Center, National Rehabilitation Hospital, Tripler Army Medical Center, Walter Reed Army Medical Center, Washington DC VAMC
 - ii. First hour – case conference, fellows rotate presenting cases
 - iii. Second hour – presentation and discussion of assigned readings
 - iv. Purpose is to prepare fellows for board certification in clinical neuropsychology
 - v. Fellows actively participate, interns attend and complete assigned readings
- 2) *Neurology Grand Rounds*
- a. Every Wednesday
 - b. Time: 9:00 AM-11:00 AM
 - c. Location: VA Auditorium (2nd Floor Main Hospital) *or* Neuropsychology conference room, 5th floor Annex
 - d. Description:
 - i. Local and national experts present topics relevant to Neurology (10:00-11:00 AM)
 - ii. Case presentation and discussion during 2nd hour
- 3) *Neuroscience Seminar (VA/ University of Maryland)*
- a. Weekly fall lecture series
 - b. Time and location: vary each year
 - c. Sample topics: neuropsychological assessment; dementia; delirium; movement disorders; seizure disorders; neuroradiology)
- 4) *HIV/Liver Disease Psychology Fellowship Training Seminar Series*
- a. Mondays from 12:00-1:00 PM
 - b. https://vaww.portal.va.gov/sites/OMHS/HIV_HCV/default.aspx
- 5) *MIRECC Science Meetings*
- a. 2nd Tuesday of each month
 - b. Time: 12:00 PM-1:00 PM
 - c. Location: MIRECC conference room: 7th floor Annex
- 6) *Geriatrics Grand Rounds*
- a. 1st Friday of each month

- b. Time: 12:00 PM-1:00 PM
 - c. Location: Baltimore VA Room 2B-136
- 7) *Psychopharmacology Case Conference*
- a. 1st Thursday of each month
 - b. Time: 12:00 PM-1:00 PM
 - c. Location: MSTF Auditorium (685 W. Baltimore St)
 - d. Calendar posted here: <http://medschool.umaryland.edu/psychiatry/default.asp>
- 8) *UM Department of Psychiatry Grand Rounds*
- a. 3rd Wednesday of each month
 - b. Time: 2:30 PM- 3:45 PM
 - c. Location: either 737 West Lombard St. 4th floor
 - d. Contact Dr. Nancy Lever (410-706-4974) or Dr. Laurel Kiser (410-706-2490) for more information.
- 9) *Neurology Town and Gown (University of Maryland Medical Center)*
- a. Day-long seminar series on current topics in neurology; current UM faculty present along with neurologists practicing in the community
 - b. Mix of clinically-oriented and research-oriented presentations
 - c. Typically occurs in June
 - d. All neuropsychology trainee strongly encouraged to attend

Neuropsychology Track Interns are encouraged to conduct their research project in an area related to Neuropsychology. Example research projects include:

- Relationship between Cognitive Scores, Psychotic Symptoms, and Performance Validity in two Samples of Veterans with Serious Mental Illness
- Cognitive Telerehabilitation in Patients with MS: Preliminary Findings
- Effects of Exercise and Cognitive Rehabilitation on Executive Functioning in Parkinson’s Disease

VA Serious Mental Illness Track (SMI)

VA-based SMI interns complete both of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

- Psychosocial Rehabilitation and Recovery Center (Baltimore)
- Residential Treatment with Psychosocial Rehabilitation and Recovery Center (Perry Point)

In addition to the Consortium didactic seminar, SMI interns participate in a monthly didactic seminar focused on psychosocial treatments and recovery. The didactic series is held in collaboration with the VA’s Interprofessional Fellowship in Psychosocial Rehabilitation and Recovery Oriented Services (PSR Fellowship). A sample schedule is provided as an illustration of what an intern might expect to participate in during their training year:

Topic	Presenter	Month
Psychosocial and Family-Based Interventions for Bipolar Disorder	Anjana Muralidharan, PhD MIRECC Postdoctoral Fellow	September
Social Cognition and SMI	Clare Gibson, PhD VAMHCS	October

The Recovery Model	Jason Peer, PhD VAMHCS	November
CBT for Psychosis	Dimitri Perivoliotis, PhD San Diego VA	January
Trauma informed care with People in Recovery from SMI	Stephanie Sachs, PhD DC VA	February
Problem Solving Therapy	Bruce Levine, PhD MIRECC VISN 3	March
Motivational Interviewing	Noosha Niv, PhD MIRECC VISN 22	April
Community Integration Strategies	Alison Taylor, OTR/L Durham VA	May
Acceptance and Commitment Therapy	Rebecca Pasillas, PhD El Paso VA	June

*Note seminars from January-June are sponsored by the PSR fellowship cross-site seminar series.

Additional training activities include the opportunity to participate in the MIRECC pharmacology case conference monthly call, MIRECC monthly journal club, and the Recovery Center Steering committee.

Former interns have completed research projects with researchers from the Mental Illness Research, Education, Clinical Center (VISN 5 MIRECC is focused on SMI and recovery) and Maryland Psychiatric Research Center (MPRC). Some examples of former interns' research projects include topics related to perceived social stigma and self-stigma, models of shared decisions making among consumers diagnosed with SMI, cognitive functioning in individuals with Schizophrenia, and qualitative outcomes of social skills interventions.

VA Trauma Recovery Track

Trauma Recovery Track interns complete both of the following four-month rotations and choose one additional rotation from the comprehensive list of available rotations (beginning on page 20).

- PTSD Clinical Team (PCT) Outpatient Program (Baltimore)&
- PTSD Clinical Team (PCT) Outpatient Program (Perry Point)
- Serving Returning Veteran-Mental Health (SeRV MH) Outpatient Program (Baltimore)

In addition to the Consortium didactic seminar, Trauma Recovery Track interns will participate in a monthly didactic seminar focused on advanced topics in PTSD assessment, intervention, and consultation. A sample schedule is provided as an illustration of what an intern might expect to participate in during their training year:

<u>Topic</u>	<u>Presenter</u>
CAPS-5 Training	Melissa Barone, PsyD
Prolonged Exposure	Melissa Barone, PsyD (Consultant PE Rollout)

Cognitive Processing Therapy	Erin Romero, PhD Erika White PhD (Consultant/ Trainers CPT Rollout)
Therapeutic Assessment	Dave O'Connor, Ph.D
Cover Letter/Application Review	Meade Eggleston, PhD
Essentials of Interviewing	Erin Romero, PhD
Cognitive Behavioral Therapy for Depression	Erika White, PhD (Consultant CPT-D Rollout)
Assessment of Symptom Validity	Dave O'Connor, Ph.D
Cognitive Behavioral Therapy for SUD	Meade Eggleston, PhD (Consultant/ Trainer CBT-SUD Rollout)
DBT skills in PTSD treatment	Liz Malouf, PhD

Additional training activities include group supervision, CPT Consultation Group, PE Consultation Group, and journal club.

Examples of former interns' research projects include topics related to PTSD self-stigma, program evaluation in outpatient clinics, evaluation of religious coping for PTSD, and integration of wellness strategies into MST programming.

University of Maryland-based Training Tracks

University of Maryland Adult-Focused Positions: General Information

There are two University of Maryland (UM) Adult-Focused Positions across two tracks:

UM Serious Mental Illness Track (UM SMI; 1 position)

UM Adult Outpatient Integrated Health Track (UM Integrated Health; 1 position)

Interns in these positions participate in year-long placements at one of two UM outpatient mental health treatment programs located at 701 West Pratt Street in Baltimore. These programs offer diagnosis and treatment of mental health and substance use disorders that are often comorbid with physical health, trauma, social, family, relationship, and legal issues. Multidisciplinary teams of social workers, psychologists, nurses, medical residents, and physicians offer psychosocial and pharmacological interventions. Both programs view recovery as a process and offer services that emphasize collaboration, hope, respect, and empowerment while emphasizing the use of evidence-based practices.

UM Serious Mental Illness (UM SMI) Track. The UM SMI Track is housed within the Department of Psychiatry in the UM School of Medicine. The intern in this position completes a primary year-long placement at the Walter P. Carter Fayette Clinic, an outpatient community mental health treatment program within the Department's Division of Community Psychiatry. The intern gains supervised experience conducting intake and diagnostic evaluation, individual and group cognitive-behavioral and behavioral interventions, individual therapy and care coordination, and psychological assessment.

Several components of the track allow interns to personalize their training experience, including specialty didactics targeting critical topics with SMI, optional minor rotations focused on a unique subgroup or care settings, and diverse research opportunities.

Please note, the UM SMI Track position WILL NOT be offered for the 2019-2020 training year. This rotation will resume in 2020-2021.

UM Adult Outpatient Integrated Health (UM Integrated Health) Track. The UM Integrated Health Track provides comprehensive assessment, psychiatric diagnostic evaluation, and intervention for people with mental health disorders. The track includes a year-long placement in the UM Adult Outpatient Psychiatry Clinic where the intern works with clients seeking treatment for affective and anxiety disorders and a range of common comorbidities. Most have experienced childhood and/or adult trauma that influences their symptoms and response to treatment. Comorbid substance use disorders and somatic health problems are common. The program serves a varied group of clients from the local community and receives referrals of patients from medical services with the University of Maryland Medical Center.

University of Maryland Child-Focused Positions: General Information

In 2019-2020 there are 4 University of Maryland (UM) Child-Focused Internship Positions across two tracks:

- UM School Mental Health Track (3 positions)
- UM Clinical High Risk for Psychosis Track (1 position)

UM School Mental Health Track. The UM Center for School Mental Health (CSMH) is nationally recognized as a leading inter-professional training program for psychology, social work, counseling, and psychiatry trainees. This is the only American Psychological Association (APA) Accredited psychology internship that offers comprehensive major rotation experiences in SMH practice, research, and policy with a goal of preparing scientist-practitioners to work in schools directly with vulnerable and underserved populations. The School Mental Health Internship Track was awarded APA's Award for Distinguished Contributions for the Education and Training of Child and Adolescent Mental Health Psychologists.

UM Child Outpatient Psychology Track. The Child Outpatient Program at the UM School of Medicine consists of rotations in specialized outpatient clinics (Mood Disorders, Trauma Disorders), the Taghi Modarressi Center for Infant Study/Secure Starts, and the Maryland Psychological Assessment and Consultation Clinic (MPACC). Patients seen during these rotations include children from birth to age 18 and their families. Although we see families from diverse ethnic and racial backgrounds, over 75% of patients are of African-American descent.

UM Clinical High Risk for Psychosis Track (CHiRP). The UM CHiRP Track is housed within the Department of Psychiatry, Division of Child and Adolescent Psychiatry in the UM School of Medicine. The CHiRP program is a SAMHSA funded research clinic for youth at clinical high-risk for psychosis, in collaboration with University of Maryland Baltimore County (UMBC), University of Maryland Baltimore (UMB), and the Maryland Early Intervention Program (MEIP). The track offers clinical, research, and policy related opportunities with leading faculty and staff in the psychosis field.

Please note, the UM Child Outpatient Psychology Track position WILL NOT be offered for the 2019-2020 training year.

Rotation Descriptions

Baltimore VA Medical Center and Annex

Addictions Treatment Program

Patient Population

The primary setting for this rotation is the intensive outpatient (IOP) component of the Acceptance and Commitment Program (ACT) at Baltimore. The ACT Program is a 12-week dual diagnosis program (substance abuse and PTSD) beginning with the four- to five-week IOP for Veterans with substance use disorders. Over 90% of ACT patients are male, 75% are members of a racial or ethnic minority group, and the median age is 45 years old. The most commonly encountered substances of abuse include alcohol, heroin (opiates), and cocaine. Other presenting addictions include to benzodiazepines, marijuana, and prescription narcotics. The majority of this population is medicated for co-occurring psychiatric illness, including PTSD, depression, bipolar illness, and severe mental illness.

Assessments, Treatments, & Supervision

During this rotation, interns will be provided with training in individual and group psychotherapy for the treatment of substance use disorders as well as co-occurring disorders, including PTSD, mood disorders, and other mental illnesses. Training and supervision will include systematic didactic and psychotherapeutic exposure to the following empirically validated psychotherapeutic approaches to treatment:

- a. The fundamentals and core change components of group psychotherapy, as researched by Yalom (1995) and fundamentals of interpersonal process therapy (IPT) in individual and group settings (Klerman et al., 2004).
- b. Extensive exposure to mindfulness-based interventions for addictions and other disorders, including Mindfulness-Based Relapse Prevention (Bowen, 2011).
- c. Methods of working with resistance and clarification of goals and values, through empirically demonstrated mindfulness strategies (Breslin, Zack, & McCain, 2002; Brown & Ryan, 2003; Hayes, 2003; Wilson, Hayes, & Byrd, 2000) within the framework of Acceptance and Commitment Therapy (ACT), Functional Analytic Psychotherapy (FAP; Kohlenberg, Hayes, & Tsai, 1993), as well as Dialectical Behavior Therapy (DBT; Linehan, 1993).
- d. Cognitive-behavioral interventions for the prevention of relapse (Brownell, Marlatt, Lichtenstein, & Wilson, 1986) focusing on the primacy of negative affect in relapse.
- e. Interns will also be trained in the fundamentals and application of Motivational Enhancement Therapy (MET; Miller & Rollnick, 1991), particularly the technique of motivational interviewing as it applies to the phases of change model of motivation (Prochaska, DiClemente, & Norcross, 1992).

Interns will participate on an interdisciplinary treatment team and will co-facilitate group therapy three times weekly, co-facilitate at least two psychoeducation groups monthly, and carry individual patient caseloads.

Interns will conduct full psychosocial assessments to include the diagnosis of, and differentiation of mild, moderate, and severe substance use disorders, learn the pharmacological correlates of behavior for major classes of substance use disorders, and differentiate and understand the phenomenological comorbidity of substance use disorders, PTSD, mood disorders, and other psychiatric disorders. Interns will employ the use of such standard instruments as the Beck Depression Inventory (Beck *et al.*, 1961), Beck Anxiety Inventory (Beck & Steer, 1990), Minnesota Multiphasic Personality Inventory-2 (Butcher *et al.*, 1989), Personality Assessment Inventory (PAI, Morey, 1991), etc., and learn how to assess for PTSD using the Clinician-Administered PTSD Scale (CAPS; Blake *et al.*, 1995) and various other trauma measures.

Each intern will case manage six to eight individual patients through the four to five-week intensive outpatient program, and will follow two to three individual patients following this rehabilitation through the stages of early recovery as part of their aftercare. They will also receive two hours of face-to-face individual supervision per week in addition to two hours of group supervision per week.

Supporting Literature

Project MATCH represents one of the largest and most comprehensive substance abuse treatment outcome studies to date (Project MATCH Research Group, 1997). Investigators followed over 1,700 alcohol-dependent clients for up to 3 years after they received treatment in one of three conditions: 12-Step Facilitation (TSF), Cognitive Behavioral Coping Skills Therapy (CBT), or Motivational Enhancement Therapy (MET). It was hypothesized that when clients are matched with the appropriate treatment approach, that outcomes would improve. On the contrary, clients in all of the treatment conditions improved, regardless of matching, and there was little difference in outcome among the three approaches.

The addiction intensive outpatient program at Baltimore has sought to improve patient outcomes by utilizing elements of TSF, CBT, and MET in its treatment programming. In 2004, when tasked with integrating aspects of its programming with that of the PTSD/Substance Abuse Residential Rehabilitation Treatment Program (PRRTP), it was decided that a more unified treatment model was needed that: 1) would be relevant in the conceptualization and treatment of both PTSD and substance abuse, as well as other emotional/behavioral disorders; and 2) would provide a less fragmented, more coherent treatment experience. In collaboration with the Trauma Recovery team, the principles and strategies of Acceptance and Commitment Therapy (2008) were adopted.

Supervisors' Training & Experience

James Finkelstein, Psy.D. is the primary supervisor for this rotation. Dr. Finkelstein earned his Psy.D. in 2003 from Loyola College in Maryland and completed his internship here at the Baltimore VA. He has continued to work as the lead psychologist in the ACT Program, supervising interns and externs in group and individual therapy, as well as facilitating an ongoing ACT consultation and training group. He has published research in the area of etiology of PTSD, psychopharmacology in psychological practice, and ethics in clinical practice. He continues to teach and lecture in the community on ACT, Mindfulness, Group Therapy, and Addictions.

Dual Diagnosis

Patient Population

The patient population of the dual diagnosis rotation is represented by a wide range of diagnostic presenting problems and levels of functioning. Interns will have the opportunity to work with Veterans diagnosed with a substance use disorder and at least one co-occurring psychiatric diagnosis. Such

psychiatric diagnoses can vary from adjustment disorders to mood disorders to serious mental illness (e.g., schizophrenia).

With regard to substance use, Veterans in the dual diagnosis rotation are generally characterized as being abstinent for at least one month, are not in imminent danger of relapsing, and generally have adequate resources for managing current life situations. The substances of use can vary, and virtually all classes of drugs are seen. Oftentimes veteran will have completed an intensive outpatient, residential, or inpatient substance use program prior to involvement in the dual diagnosis program. This patient population is also diverse in terms of age, gender, socioeconomic status and cultural background.

Treatment and Supervision

For this rotation the primary focus will be the provision of psychotherapy. All cases referred to interns will have previously had a full psychosocial intake completed, and additional formalized assessment will not be required. However, interns will be asked to conduct an informal initial assessment of the Veteran to assist with treatment planning. While the focus of this training experience is on provision of psychotherapy, interns will have the opportunity to conduct formal psychological assessments to clarify diagnosis, motivation for treatment, and treatment recommendations utilizing traditional psychometric instruments such as the MMPI2, PAI, and other selected tests as indicated. Interns will usually not have more than two full evaluations per rotation.

Treatment interventions will vary depending on the therapy context, but will generally incorporate a transdiagnostic approach to treatment. This approach operates on the assumption that many normal human processes can lead to suffering, and offers an alternative to the prevailing DSM-5 diagnostic system. Whereas some theoretical approaches to therapy may attempt to treat one diagnosis before addressing another, a transdiagnostic approach attempts to identify and treat core mechanisms that may be influencing a variety of symptoms. Based on experience in the dual diagnosis program, this offers a specialized yet comprehensive approach for working with this clinical population.

Given the wide array of presenting problems and comorbidities, the dual diagnosis program draws heavily on a variety of clinical approaches, including Acceptance and Commitment Therapy (Hayes et al., 1999), Dialectical Behavior Therapy (Linehan, 1993), and Mindfulness-Based Relapse Prevention (Bowen et al., 2010). Interns are not required to have prior experience using these therapeutic approaches but are simply required to present with the desire to learn and enhance clinical skills. Journal articles, books, and other resources will be utilized and reviewed to provide sufficient theoretical background. Interns will also be strongly encouraged to participate in regular mindfulness practice to help inform their clinical practice interventions.

With regard to caseload, interns will be expected to see 4-6 individual clients, co-facilitate at least one group psychotherapy meeting, and conduct one psychosocial intake assessment per week. Interns will receive at least one hour of direct individual supervision each week, and at least one session of live supervision per week. Live supervision entails the supervisor observing an individual therapy session live as it happens using overhead video cameras and recording equipment. The ultimate goal of live supervision is to collaborate rather than correct, adhere to a protocol, or add undue stress. In other words, this is not an audition or attempt to “catch you” but rather is done to stimulate critical thinking, generate ideas, pool knowledge, and provide the highest quality of care. As a further part of live supervision, interns will be asked to consult with their supervisor in the therapy room at the conclusion of each session, with the client present. This process draws on a technique of Yalom (1975) for building therapeutic rapport, fostering transparency, modeling of behaviors, and affording the client the opportunity to hear important consultation regarding their treatment.

When more than one intern is in training, interns may have an opportunity to observe each other’s work during these live supervision sessions. This can very nicely compliment the experience of receiving

supervision while conducting therapy. Interns who are observing from “behind the mirror” have an opportunity to hear the supervisory comments and also have the luxury of processing the events of the session without actually having to conduct the therapy.

Supporting Literature

Acceptance and Commitment Therapy (ACT) is a theoretical approach to therapy representing a third wave behavioral treatment. This approach emphasizes changing the way a client relates to their internal experiences (e.g., trying to control them), rather than attempting to change the frequency, form, or content associated with these experiences. This approach to therapy reflects a departure from second wave behavioral treatments, such as Cognitive Behavioral Therapy, where the emphasis may be placed on helping clients challenge, restructure, or change internal experiences. By targeting core ACT processes, the ultimate goal is to help clients clarify and live consistently with personal values.

Research examining the efficacy of ACT is a burgeoning field of study. There have been nearly 60 randomized controlled trials conducted, and nearly half of them have been published within the past several years. Various meta-analyses suggest that ACT is as effective when compared to Cognitive Behavioral Therapy (CBT), and demonstrates significantly greater improvements when compared to treatment as usual or control conditions (A-Tjak et al., 2015; Hayes et al., 2006; Ost et al., 2014; Powers et al., 2009, Ruiz et al., 2010; Smout et al., 2012). This is observed when considering both outcomes of symptom reduction (e.g., Ost et al., 2014) and outcomes such as life satisfaction/quality of life, and behavioral change measures (e.g., A-Tjak et al., 2015). The extent to which ACT has been investigated with different populations is also striking. For instance, studies have examined ACT as a treatment for physical pain, depression, stress at work, anxiety, weight loss, substance use, smoking, disordered eating, psychosis, personality disorders, somatization, stigma, parenting, and others. This can highlight the transdiagnostic nature of ACT, where it can be useful for a wide range of clinical symptoms, and common difficulties such as stress at work, weight loss, and parenting. By targeting common mechanisms, this approach works to undermine behaviors or mechanisms that lead to increased suffering in a variety of settings and populations (Harris, 2009).

Dialectical Behavior Therapy (DBT) also represents a third wave behavioral approach to treatment. This approach was initially developed for treatment of individuals with Borderline Personality Disorder, and is now utilized with individuals with co-occurring psychological disorders, and suicidal behaviors (Dimeff et al., 2008). In a similar fashion to ACT, the ultimate goal of DBT is to help clients build a life worth living, and utilizes techniques to help manage problematic behaviors, and balancing acceptance and change.

Various reviews have highlighted the effectiveness of DBT (Chambless et al., 1998; Oldham, 2006; Kliem et al., 2010), and emerging evidence also supports the use of DBT with psychological disorders and co-occurring substance use disorders. Specifically, various RCTs have supported a DBT protocol for treating borderline personality disorder and substance use disorders, suggesting decreased use of substances and greater social adjustment compared to control participants (Linehan et al. 1999; Linehan et al., 2002; Linehan et al., 2009; van den Bosch et al., 2002). This adaptation to traditional DBT interventions has allowed clinicians to more fully address issues related to substance use. Like the clinical approaches mentioned above, Mindfulness-Based Relapse Prevention (MBRP) aims to develop mindfulness skills for managing craving experiences and negative affect (Bowen et al., 2010). This approach differs with respect to the primary emphasis being on mindfulness as a vital component of being able to identify and increase tolerance of difficult experiences to avoid relapse. It is through this active practice of mindfulness that this approach aims to help clients increase ability to make conscious and mindful choices about substance use. Few studies have examined the effectiveness of MBRP, but results of four studies to date have suggested positive outcomes of reduced substance use, cravings, and reactivity to drug cues (Zgierska et al., 2009; Bowen et al., 2011).

Overall, these approaches represent various, but not an exhaustive list of, approaches that are highly emphasized in the dual diagnosis rotation. The ultimate goal is to provide patient-centered quality care that will fit the Veteran's unique cultural, spiritual, and clinical needs.

Supervisors' Training & Experience

Arthur Sandt, Ph.D., Dr. Sandt initially received training in Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, and Contextual Constructivism as a graduate student at Temple University. While completing his doctoral degree, Dr. Sandt relocated to Boston to complete an external practicum at the National Center for PTSD-Boston, which emphasized evidence-based assessment and treatment of PTSD. He then completed his clinical internship at the Baltimore VA, including rotations in the intensive outpatient substance use program, trauma recovery program, and dual diagnosis program. Providing further breadth of experience, Dr. Sandt also worked at the VISN-5 Mental Illness Research, Education, and Clinical Center (MIRECC) conducting research assessments and leading therapy groups with Veterans with serious mental illness.

Dr. Sandt was hired as a staff psychologist at the Baltimore VA and has been working in the Substance Abuse Treatment Program for approximately 3 years. He currently provides outpatient care by providing a range of services to Veterans with co-occurring disorders. Current clinical interests include transdiagnostic approaches to treatment, optimal mental health, clinical supervision, and neurofeedback. Dr. Sandt's research interests include emotion, motivation, and psychophysiology to help understand psychopathology, human suffering, and optimal mental health.

Health Psychology General

Patient Population

Interns will have the opportunity to work with three medical populations during this rotation: individuals with diabetes or other endocrine disorders, individuals with cancer, individuals with end-stage organ diseases or life-threatening blood diseases who are being considered for solid organ or bone marrow transplantation, and individuals who are post-transplant. Additionally, there may be some exposure to mental health evaluations for individuals who are being considered for bariatric surgery and/or experience with groups for those who are either pre- or post-bariatric surgery.

Patients with diabetes/endocrine disorder: These patients are referred to this specialty medical clinic when their diabetes is not well-controlled or when they are diagnosed with an endocrine problem such as hyper- or hypothyroidism. The average age range is 40's to 60s. The majority of the patients are male (90%) and about 75% of the patients are African-American. The most common psychiatric comorbidities are Major Depressive Disorder but typical referral questions usually request assistance with helping the veterans improve adherence to their medical, dietary, and exercise regimens.

Patients with Cancer: These patients are referred from various inpatient and outpatient programs and teams within the VA hospital system. The majority of referrals are generated from radiation-oncology, chemotherapy-oncology, and palliative care/hospice programs. The age range is primarily 40s to 70s and predominant diagnoses are lung and head/neck cancers. Psychological support may be provided via "warm-hand off" in chemotherapy infusion clinic, radiation-oncology exam rooms, and in ICU or other inpatient units. When outpatient treatment is feasible and appropriate, work tends to be relatively short-term and focus mainly on coping with acute or chronic illness, which may or may not include emphasis on mental health diagnoses. Overall, these patients tend to have multiple co-morbid medical conditions (such as diabetes, hypertension, chronic pain). The most common psychiatric comorbidities are Adjustment Disorders, Substance-related Disorders and Anxiety disorders due to medical condition(s).

Patients who are being considered for transplantation and/or who have received a donated organ: These patients are referred for psychological assessment as part of a comprehensive medical evaluation to determine their suitability for solid organ or bone marrow transplantation. Psychological support is provided, when appropriate, to those who would benefit prior to transplantation. Interventions are typically grounded in Motivational Interviewing (MI), mindfulness, Acceptance and Commitment Therapy-based (ACT) interventions, and solution-focused or coping-based models. Most of the patients are male and range in age from late 40s to mid 60s; approximately 40%-50% are African-American. The most common psychiatric comorbidities are Adjustment Disorder, Major Depressive Disorder, and comorbid substance use disorders.

Assessments, Treatments, & Supervision

Diabetes/Endocrine Clinic: In this clinic, interns will learn about the considerably complex medication regimens utilized to treat diabetes and will become members of an important multidisciplinary team. The intern will learn to complete brief, health psychology evaluations that may inform the team's approach to care, as well as dictate specialty mental referrals and/or in-clinic follow-up for brief psychological intervention. Specific recommendations to the team frequently consist of ways in which to improve communication/rapport with the veteran, to increase health literacy, and to ameliorate adherence. The intern will also provide brief therapy to veterans who experience difficulty adhering to the medication regimen and/or difficulty maintaining healthy lifestyle changes. The expected case load is 3 to 5 patients. Motivational Interviewing is the most commonly used therapeutic intervention. Additionally, the intern has the opportunity to conduct bariatric surgery evaluations, and/or participate in psychological group intervention for pre- and post-bariatric surgery patients, as well as monthly interdisciplinary bariatric team meetings.

Oncology Clinics: In these settings, interns will learn to complete brief, health psychology evaluations of patients with cancer by conducting clinical interviews supplemented by instruments that can be administered and interpreted quickly (e.g., the BDI, BAI, and/or Cancer Behavior Inventory). Interns will frequently provide verbal feedback and recommendations to the patients' physicians based on the results of their assessments. Interns can expect to complete 4-5 assessments of cancer patients while on rotation. Interns will also have the opportunity to conduct individual, outpatient psychotherapy, which is typically short-term and problem/coping-focused. Expected caseload is 3 patients. Appropriate strategies include: mindfulness-based skills, cognitive-behavioral skills training (including relaxation and stress management), motivation enhancement, and supportive therapy.

Transplant Consults: Interns will utilize a semi-structured interview designated for VA-wide use as part of their psychological assessment of candidates for transplantation. This interview will be supplemented by review of the patient's electronic medical chart, administration of the BDI and BAI (to assess symptoms of affective distress), administration of a brief cognitive screener (e.g. MoCA), and administration of the MBMD (to determine if the patient is engaging in impression management and to assess personality functioning). Based on an integration of these sources of data, the intern will make a judgment about the patient's current psychosocial readiness for transplantation and, if appropriate, make recommendations for increasing the patient's transplant readiness. Interns will have the opportunity to provide brief intervention, when appropriate, to increase readiness for transplant. Interns can expect to complete 3-4 transplant evaluations.

Supervisor's Training & Experience

Interns on this rotation will receive 2 hours of scheduled, face-to-face supervision each week from Dr. Buchanan. Dr. Buchanan is also available for additional supervision or consultation as needed, by phone or in person. Dr. Juli Buchanan has worked in variety of clinical settings providing behavioral health services to adults and adolescents. She has specific interest in behavioral medicine and, as such, has worked with patients diagnosed with cancer, chronic and acute pain, heart disease, end-stage liver

disease, HIV, hepatitis C, and diabetes. Dr. Buchanan received her Psy.D. in Clinical Psychology from Indiana State University where she was also project manager and lead clinician on a NIH-funded study treating obesity-related disorders with Mindfulness-based cognitive therapies. After completing an internship at the Vanderbilt University/Tennessee Valley Veterans Administration Consortium, Dr. Buchanan joined the Baltimore-based Federally Qualified Health Center (FQHC), Chase Brexton Health Care (CBHC) where she was staff psychologist, Director of Behavioral Health and later, Chief Behavioral Health Officer. In her various roles, she led several major multi-disciplinary initiatives including Behavioral Health/Primary Care Integration, CBHC Open-Access “Pod” (an integrated, open-access primary care clinic for patients who were high utilizers of health care services), as well as facilitated major expansions to Substance Use Disorders clinic, Lesbian, Gay, Bisexual, Transgender (LGBT) services, and extern and post-doctoral level training programs. For the past two years, Dr. Buchanan has served as Director of Integrated Care at Way Station Inc., where she has focused primarily on managing Way Station’s “Health Home.” Health Home is an Affordable Care Act program designed to support the integration of primary care and nurse care management services into mental health facilities serving severely mentally ill individuals in community. Within the larger Health Home initiative, Dr. Buchanan developed population health, preventative initiatives to address metabolic syndrome, as well as led collaborative behavioral health/medicine efforts to design diabetes management protocols utilized by behavioral health, front-line lay staff to facilitate patient safety. Dr. Buchanan’s interests continue to reside in areas of diabetes management and adjustment to acute/chronic illness.

Health Psychology – Neurology/Chronic Pain

Patient Population

During this rotation, interns will have the opportunity to work with one of the largest and most diverse medical populations at VAMHCS: individuals with chronic non-cancer pain, including headaches. The setting is within the Department of Neurology, under the Chronic Pain Service.

The Chronic Pain Management service operates as a consultative service for patients with chronic pain. These patients have been referred by their primary care providers, orthopedic providers, or similar, to the VAMHCS chronic pain specialty clinic for re-evaluation of their pain management plan. The duration of time spent with the specialty clinic ranges from one visit to long-term (e.g. 1 year) depending on the individual’s assessment and plan. The age range is 20s to 80s, 20 to 25% of the patients are female, and approximately 50% are African-American. The most common presenting medical complaint is spinal pain. The most common co-occurring psychiatric disorders are Major Depressive Disorder and PTSD.

Assessments, Treatments, & Supervision

Interns will perform a comprehensive psychological evaluation of patients who are presenting to the Pain Clinic for their initial visit. This evaluation consists of: a semi-structured interview, a review of the patient’s electronic medical chart, the Patient Health Questionnaire (PHQ-9), the Pain Catastrophizing Scale (PCS), the Primary Care PTSD Screen (PC-PTSD), and the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R). In addition, all patients are asked to complete the numerical pain scale and interference items from the Brief Pain Inventory to assess pain severity and impact on function. Interns may have the opportunity to conduct brief neurocognitive screens to aid in referrals. Based on their interests, interns have the opportunity to use other pain-specific assessment instruments, such as the Multidimensional Pain Inventory (MPI), the Chronic Pain Acceptance Questionnaire (CPAQ), and the Short Form McGill Pain Questionnaire (SF-MPQ), as well as health psychology-specific instruments such as the Millon Behavioral Medicine Diagnostic (MBMD). Interns can expect to complete at least six comprehensive evaluations of pain patients, and can expect to communicate findings to and collaborate on treatment plans with medical providers, both orally in clinic and verbally through written reports.

Interns will receive training in a variety of empirically-supported behavioral interventions for the treatment of chronic pain patients. Individual treatments offered to pain patients include biofeedback and cognitive-behavioral therapy for chronic pain. Expected caseload is three to five patients. Interns are expected to co-lead a CBT-CP group. Interns will be expected to participate in the monthly Interdisciplinary Pain Team meeting (IDT), during which the most complex pain patients are discussed for coordination of care among pain specialty providers, mental health, and primary care. Opportunities to learn biofeedback training may also be available. In addition, interested interns may receive training in assessment and treatment of chronic patients with co-occurring substance use problems, conduct ACT for Chronic Pain (ACT-CP), or other interventions (e.g. Mindfulness Based Stress Reduction for chronic pain).

Centers of Excellence – MS and Epilepsy: Housed within the department of Neurology, Baltimore is the coordinating center for all MS Centers of Excellence in the region and for a number of studies related to the diagnosis, monitoring, and treatment of Multiple Sclerosis and Epilepsy. While not officially part of the rotation, interested interns may find opportunities for assessment and intervention within this service, for example, CBT for nonepileptic seizures. Other interns have taken “general neurology” health psychology cases, including tic disorders and polymyositis.

Supporting Literature

There is ample empirical support for the use of cognitive-behavioral therapy in patients with chronic pain, whether in individual sessions or in a group format (e.g., Basler, Jaekle, & Kroener-Herwig, 1997; Keefe *et al.*, 1990; Turk, 2003). Relaxation training is widely recognized as useful for treating chronic pain and a recent Cochrane evidence-based medicine review supported its use (Ostelo *et al.*, 2005). Biofeedback training (which incorporates relaxation) has been found to be clinically useful for the treatment of headaches (as reviewed in Arena & Blanchard, 2002) as well as for chronic musculoskeletal pain (Flor & Birbaumer, 1993). Finally, emerging evidence suggests that Acceptance and Commitment Therapy-based interventions also are promising for treating a chronic pain population (Dahl, Wilson, & Nilsson, 2004).

Supervisor’s Training & Experience

Dr. Perra earned her doctorate in clinical psychology from Loyola University Maryland, where she worked in academic medical centers and community health centers with patients dealing with a range of chronic illnesses, including HIV, stroke, spinal cord injury, and chronic pain. She completed her internship at the Medical College of Georgia/Charlie Norwood VA Medical Center consortium in the Medical Psychology track, where she had the opportunity to work in a variety of areas in general and medical psychology. She joined the VA Maryland Health Care System for a postdoctoral fellowship in health psychology, specializing in assessment and treatment of patients with HIV and hepatitis C, after which she returned to chronic pain in the Neurology service. Her current clinical and research interests include developing and growing interdisciplinary treatment teams, cognition and chronic illness, and clinical supervision.

Neuropsychology

General

The Neuropsychology Specialty Track within the VAMHCS/UMMS Consortium adheres to criteria and guidelines developed by Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology. Accordingly, interns will spend a minimum of 50% of their training year involved in clinical, didactic, and empirical endeavors in neuropsychology. The program is designed to prepare students for post-doctoral fellowships in neuropsychology. To achieve this objective,

interns in this program will do two full rotations in neuropsychology at the Baltimore Medical Center/Annex and their research experience will be focused in areas pertinent to neuropsychology. During the third rotation, the intern maintains a minor rotation in our service. Interns are encouraged to attend regional and national conferences. Our previous interns have been successful in obtaining post-doctoral fellowships both locally and nationally and opportunities may exist for interns to develop their own research funding to support post-doctoral training endeavors.

Patient Population

Veterans with medical, neurological, and psychiatric disorders are referred from various clinics and units throughout the medical center for neuropsychological assessment. Diagnoses include neurodegenerative, neuropsychiatric, endocrine, infectious, seizure, and vascular disorders as well as tumor and head trauma. We also see patients referred for war-related injuries and complaints. Patients come from different ethnic backgrounds and from all adult age ranges. In view of the Veteran population served, a substantial number of patients are 50 years of age and older, although changes in this population have led to increasing referrals of returning Veterans, who have been as young as 22 years old.

Assessments, Treatments, & Supervision

Neuropsychology is primarily a consultative and assessment service. Test batteries vary depending on the level of impairment of the patient and the nature of the referral question. Interns learn test administration via direct observation and mentoring. Once interns can function autonomously, they interview patients with the supervisor and then proceed with the assessment. Patient histories and examination findings are reviewed with the intern. Interns generate reports that are reviewed in detail by their supervisor(s). During the major neuropsychology rotations, interns assess 1-2 outpatients and 1-2 dementia clinic patients per week.

Treatment is also an integral component to the internship program. Interns will have a minimum of 1-2 outpatient treatment experiences (e.g., cognitive rehabilitation, psychotherapy, dementia follow-up, other groups) throughout the training year. Experiences providing treatment may be available during Neuropsychology minor rotations.

We utilize a tiered supervision model. Therefore, at times interns will be supervised, in part, by postdoctoral fellows and in turn, they may have the opportunity to provide supervision to externs.

In addition to weekly individual and group supervision within the Neuropsychology section, interns may attend the following activities at various intervals:

1. Neuropsychology Fellowship Video-Teleconference with VA/DoD Sites
2. Neuropsychology case conference
3. Neuropsychology morning report
4. Geriatric assessment clinic supervision
5. Neuropsychology treatment supervision
6. Neurology grand rounds
7. Neuropsychology journal group
8. Geriatric psychiatry rounds
9. Psychiatry Neuroscience Course
10. Select meetings of the MS & Epilepsy Centers of Excellence

Research

Interns are required to complete a research project during the internship year. The general expectation is for interns to formulate a novel research question at the beginning of the year, gather/analyze data

throughout the year, and present results at the end of the year. Please see the attached sheet for a description of ongoing research studies.

Clinical Training Program

The VAMHCS Neuropsychology section takes pride in the breadth and depth of our training programs. In addition to internship training, VAMHCS Neuropsychology staff actively participate in training 2-4 doctoral candidates per year in formal externships. VAMHCS Neuropsychology also has an established two-year, APA-accredited general Clinical Neuropsychology postdoctoral fellowship. Two additional postdoctoral fellowship programs were recently established, with fellows initially enrolling in these programs in September 2014. These new programs include a one-year joint fellowship in Health Psychology and Neuropsychology with an emphasis in HIV/Liver Diseases and a two-year Clinical Neuropsychology fellowship in the assessment and treatment of neurologic disorders.

Our training model is based on information and recommendations from The American Board of Professional Psychology, Division 40 of the American Psychological Association, the Association of Internship Training in Clinical Neuropsychology, and the Houston Conference on Specialty Education and Training in Clinical Neuropsychology.

VAMHCS Neuropsychology Staff: Training & Experience

Jeremy Carmasin, Ph.D. obtained his doctorate in Clinical Psychology from the University of Louisville. He completed his predoctoral internship at the VA Western New York Healthcare System, and postdoctoral fellowship in Clinical Neuropsychology at Dartmouth College/Dartmouth-Hitchcock Medical Center. Dr. Carmasin's research interests include the assessment of early cognitive change in older adults and how awareness of deficits informs diagnosis and treatment, particularly in the domains of memory and executive functioning.

Moira Dux, Ph.D. is the Co-Training Director for the VA Postdoctoral Fellowship in HIV/Liver Diseases. She earned a doctorate in clinical psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training (neuropsychology track) at the VA Maryland Health Care System/ University of Maryland Medical Center. She then completed a research neuropsychology fellowship at the Baltimore VA. Dr. Dux was the recipient of a VA Career Development Award examining the effects of high-intensity aerobic exercise on autonomic, cognitive, and affective function post-stroke. Primary research interests include evaluation of exercise and cognitive rehabilitation interventions to improve cognitive, psychological, and physical function in neurologic and chronic disease populations (e.g., HIV/HCV, stroke, MS).

Anjeli Inscore, Psy.D., ABPP-CN is the Director of Training for the Postdoctoral Fellowship in Clinical Neuropsychology. She earned a doctoral degree from Loyola University. She completed a one-year research postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. She then completed a two-year clinical postdoctoral fellowship in neuropsychology at the Johns Hopkins Department of Psychiatry and Behavioral Sciences. Dr. Inscore holds an appointment as a Research Associate at the University of Maryland, School of Medicine. Her research is in conjunction with the University of Maryland and the VA Geriatric Research Education and Clinical Center (GRECC) with a primary interest in the neurocognitive, psychological, and health benefits of exercise in overweight and obese individuals. She received a Nutrition Obesity Research Center (NIDDK-funded) Pilot and Feasibility grant to study yoga as an intervention to treat obesity in postmenopausal women. She also has a research interest in geriatrics/dementia and is in the process of creating archival and prospective databases that will include medical, functional, and cognitive data on patients evaluated in the Geriatric Assessment and Dementia Evaluation, Management, and Outreach (DEMO) clinics.

Terry Lee-Wilk, Ph.D. is the Program Manager of Neuropsychology and Co-Director of the Postdoctoral Fellowship in Clinical Neuropsychology with an Emphasis in Neurologic Disorders. Dr. Lee-Wilk earned a doctorate in clinical/community psychology from the University of Maryland College Park. She completed internship at the University of Maryland Baltimore in Child Psychiatry and one year of postdoctoral training at Children's National Medical Center. She subsequently completed a two-year postdoctoral fellowship in Neuropsychology at the VAMHCS/University of Maryland School of Medicine. She is the lead neuropsychologist at the Multiple Sclerosis Centers of Excellence and is also very involved with the Infectious Disease clinics. She serves as a volunteer clinical instructor at the University of Maryland, Department of Pediatrics. Currently, her research is related to cognitive tele-rehabilitation for patients with multiple sclerosis.

Kristen Mordecai, Ph.D. is the Co-Director of the Postdoctoral Fellowship in Clinical Neuropsychology with an Emphasis in Neurologic Disorders. She earned a Ph.D. in clinical psychology from Rosalind Franklin University of Medicine and Science, in the program's neuropsychology track. She completed her pre-doctoral training in clinical psychology focused in general and geriatric neuropsychology within the Boston Consortium in Clinical Psychology at the Veterans Affairs Boston Health Care System. Her two-year postdoctoral fellowship in neuropsychology was completed at the Veterans Affairs Maryland Health Care System within the Integrated Fellowship in Traumatic Brain Injury and Trauma Recovery in Returning Veterans program. She is the Neuropsychology liaison at the Baltimore VA Epilepsy Center of Excellence. Her research interests include the cognitive effects of neurologic conditions such as Parkinson's disease, dementia, and MS as well as the development of cognitive rehabilitation and telemental health programs to address cognitive symptoms.

Patricia Ryan, Ph.D. earned a Ph.D. in counseling psychology from Fordham University, after obtaining a master's degree in developmental psychology from Teachers College, Columbia University. She completed her internship and additional postdoctoral training at the Rusk Institute of Rehabilitation Medicine, New York University Medical Center. Dr. Ryan also completed a two-year postdoctoral fellowship in rehabilitation psychology and neuropsychology at the Johns Hopkins Department of Physical Medicine and Rehabilitation. She is a member of the interdisciplinary Polytrauma Support Clinic Team, working with Veterans with traumatic brain injury. Within that clinic and the general consultation clinic, she provides assessment, cognitive rehabilitation and psychotherapy for Veterans with traumatic and acquired brain injury. Her research interests include the efficacy of various cognitive remediation modalities, as well as depression after TBI and stroke. She is currently a research team member on a multi-site randomized control trial of multifamily group treatment in returning Veterans with a history of mild TBI.

Megan M. Smith, Ph.D. obtained her doctorate in clinical psychology from The Pennsylvania State University. She completed her predoctoral clinical internship and postdoctoral training in clinical neuropsychology at Brown University. From 2009-2014, she was an assistant professor in the Department of Psychiatry at the Carver College of Medicine at the University of Iowa. Her major areas of research interest are cognition in neurodegenerative disorders and the neuropsychological correlates of depression. She was the recipient of a National Academy of Neuropsychology Clinical Research Grant to examine the relationship between inflammatory markers and cognition in multiple sclerosis.

Primary Care-Mental Health Integration (PCMHI) Rotation - Baltimore

Patient Population

The primary care clinic in Baltimore is a large, urban clinic, with approximately 27 primary care providers and 40 internal medicine residents serving 38,000 Veterans. The average age of Veterans in this clinic is 60 and the majority (90%) are male. Veterans receive care within Patient Aligned Care Teams (PACT), which are patient-centered medical homes that are structured to provide coordinated, accessible,

and patient-centered healthcare. As all PC-MHI providers do, interns will function as integrated members of the PACT by providing consultation to primary care providers and the PACT teams, having availability to see patients on the day of their primary care visit, and attending and contributing to PACT team meetings.

Assessments, Treatments, & Supervision

Interns will have the opportunity to provide brief (30 min.), targeted behavioral health assessments for Veterans who are referred by their primary care team. The purpose of assessments in PC-MHI is to clarify the presenting problem and triage the Veteran to the appropriate treatment setting. Veterans who are appropriate for treatment in PC-MHI include those with common, uncomplicated presenting problems, such as depression, anxiety, tobacco use, obesity, adjustment issues, adherence problems, uncomplicated grief, and chronic pain. Most patients presenting to PC-MHI can be treated/managed within this setting. Interns will learn to tailor assessments to the particular Veteran and his or her presenting problem. Depending on patient presentation and the nature of the referral, assessments may include administration of brief measures, such as the Patient Health Questionnaire-9 (PHQ-9), Posttraumatic Stress Disorder Checklist (PCL), and Generalized Anxiety Disorder-7 item scale (GAD-7). Interns will be able to refer patients to one of several psychiatric residents who provide 20 hours of medication management per week. Interns may also have the opportunity to complete pre-transplant evaluations on this rotation.

Interns will have availability to see both scheduled patients and walk-in patients (warm hand offs) from primary care providers. Patients who are typically referred to PC-MHI include those with depression, substance use problems, PTSD, anxiety, tobacco use disorders, obesity, diabetes, chronic pain, and insomnia. Treatment in the primary care setting is brief (up to 6, 30 minute sessions) and evidence-based. Interns will utilize a wide variety of brief interventions, including behavioral activation, motivational interviewing, relaxation training, and brief CBT. Interns may have the opportunity to provide individual as well as group treatments. Group opportunities may include diabetes management, problem-solving training, weight management (MOVE!), chronic pain, and mindfulness-based stress reduction

Supporting Literature

Integrated Primary Care: Integrated care can increase access to mental health care, reduce the burden on specialty mental health clinics, and modify willingness of primary care providers to address mental health concerns (Brawer, Martielli, Pye, Manwaring, & Tierney, 2010; Felker et al., 2004). It may also serve to reduce the stigma associated with mental health treatment, as a higher number of patients engage in treatment when it is integrated into primary care versus when it is delivered in specialty mental health (Bartels, 2004). Primary care providers have positive perceptions of integrated care, with the majority reporting that integrated care leads to better communication between primary care providers and mental health providers, less stigma, better coordination of care, and better management of depression, anxiety, and alcohol problems (Gallo et al, 2004).

Brief Interventions: Interventions utilized in this setting are brief and evidence-based. When designing interventions, PC-MHI clinicians take into consideration the best available evidence along with patient characteristics and clinical expertise to develop a treatment plan that is grounded in research and also tailored to each individual Veteran's specific needs. Given the breadth of patients seen in primary care, only a review of some of the most common interventions will be discussed. Examples of common interventions include behavioral activation, brief CBT, and motivational interviewing.

Brief (4 session) primary-care based behavioral activation has been shown to reduce symptoms of both anxiety and depression in Veterans (Gros & Haren, 2011). Brief CBT has been shown to be effective in the treatment of depression and anxiety (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Nieuwsma, 2012). A recent Cochrane review found that CBT for pain has positive effects on disability, mood, and pain catastrophizing (Williams & Eccleston, 2012). Initial research suggests that brief (4-6

sessions) cognitive-behavioral treatment for PTSD in primary care may improve symptoms of PTSD and depression for younger Veterans (Cigrang et al., 2011). Brief behavioral intervention has been shown to be effective in treating insomnia (Buysse, 2011). Finally, brief motivational interviewing has been shown to reduce risky drinking behavior (Brown et al., 2010).

Supervisor's Training & Experience

Supervision will be a minimum of two hours per week, with availability for “on the spot” supervision and consultation as necessary. Outside of supervision, interns will have a variety of learning opportunities that are relevant to the primary care setting and appropriate to the level of experience and specific interests of the intern. For example, interns may shadow PACT team members (nurses, primary care providers, dieticians), present health psychology topics to primary care providers at meetings, and become familiar with relevant literature on collaborative healthcare.

Dr. Michele Crisafulli earned her doctorate in Human Services Psychology from the University of Maryland, Baltimore County with concentrations in clinical and community/applied social psychology. Her graduate training focused on the biopsychosocial model of health and wellness; motivation enhancing interventions for health behavior change; acceptance- and mindfulness-based interventions; substance use disorders; stigma associated with various conditions; underserved populations (especially ethnic and racial minority groups and the LGBTQ community); and program development, implementation, and evaluation. Dr. Crisafulli completed internship (comprehensive track) and received postdoctoral training (PC-MHI) at VAMHCS prior to becoming a staff psychologist in PC-MHI at the Baltimore VAMC in 2017.

Dr. Eileen Potocki earned her doctorate in clinical psychology from the Florida State University. She completed her internship at the Johns Hopkins Health System with rotations in behavioral medicine, psychological testing, psychogeriatrics and inpatient psychiatry. Her dissertation research involved testing a biopsychosocial model of cardiovascular disease. She spent the majority of her career collocated with physicians serving the underserved and uninsured in Federally Qualified Healthcare Centers (FQHC) in the Baltimore area. Dr. Potocki held the position as Division Director of Behavioral Health at Baltimore Medical Center, Inc., a FQHC which served 50,000 internal medicine patients in multiple sites. She was an advocate for proper and judicious application of the “Integrated Care” model in a primary care environment dominated by non-psychologist providers. She has been exposed to a very large and diverse patient population. Dr. Potocki also has worked with the refugee population and is fully bilingual (Spanish).

Psychosocial Rehabilitation and Recovery Center

Patient Population

The Psychosocial Rehabilitation and Recovery Center (PRRC) treats Veterans who present with a broad spectrum of psychiatric illnesses. Our population includes Veterans with schizophrenia, mood disorders, anxiety disorders including PTSD, and personality disorders. Many of the Veterans also have a co-morbid substance use disorder or substance use-related problems. The PRRC is an outpatient transitional learning center designed to support recovery and integration into meaningful self-determined community roles for Veterans challenged with severe mental illness. Referrals to PRRC are for Veterans who need additional support, education, therapy and care coordination to manage in the community. Veterans remain in the PRRC for a time limited duration per their individual needs and recovery goals and participate in daily intensive programming. Aftercare/transition plans include participation in identified groups or activities consistent with their recovery plans. Some interns on this rotation may be able to participate in activities of the Mental Health Intensive Case Management (MHICM) team. This program provides community based case management for Veterans with SMI who need intensive services and have a history of frequent or extended psychiatric hospitalizations and have been minimally responsive to the hospital based treatment.

Assessment and Intervention Training

In the PRRC, interns will be provided with training in individual, family, systems and group therapy for the treatment of serious mental illness (SMI). Group experiences can include cognitive therapy groups, social skills training (Bellack, 2004), mental health recovery groups (Frese *et al.*, 2001) as well as co-leading an ACT treatment protocol for individuals with SMI (Bach & Hayes, 2002). The intern is also expected to develop and lead their own group bases on their interests and the Veteran's needs. The intern will be supervised in individual therapy including the application of cognitive therapy for treatment of SMI (Bellack, 2004; Kingdom & Turkington, 2005). Also, interns will be trained in supportive individual therapy, psychoeducation group therapy, and supportive family therapy. Interns can develop the rotation based on their interests and needs. The patient load will include 2-4 assessments, 3-4 individual psychotherapy patients in addition to co-leading at least 3 groups. Supervision will include 1-2 hours per week with Dr. Weissman and additional supervision depending on clinical activities.

Supporting Literature

The PRRC is guided by the Recovery Philosophy (Bellack, 2006) . We attempt to assist Veterans in defining and pursuing a self-determined personal vision and mission for their lives. It is the role of the clinician in the PRRC to collaborate with the Veteran to promote realization of their goals thru support, education an effective treatment. . There is support in the literature for various types of interventions, including: problem-solving skills; cognitive-behavioral therapy that includes support and education and is aimed at specific areas of deficit (*e.g.*, medication non-compliance, treatment-refractory auditory hallucinations, paranoid ideation, etc.); social skills training as a targeted treatment for social impairment; and family intervention programs that provide a combination of education about the illness, emotional support for the family, crisis intervention and motivational enhancement. (see Lehman *et al.*, 2003, Schizophrenia Patient Outcomes Research Team: Updated Treatment Recommendations for a review, also Bellack, 2004). Interns will receive training in all of these interventions and more. In addition, frequent questions arise as to the accuracy of diagnosis for specific patients. A number of issues complicate the diagnostic picture, including co-morbid substance abuse, overlap with other major mental illness (*e.g.*, mood disorders with psychotic features), and dementia. It is therefore important that the intern become familiar with the criteria for serious mental illnesses, including schizophrenia-spectrum disorders, bipolar disorder, and major depression, as well as substance use disorders as described in the DSM-IV.

Supervisors' Training & Experience

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a postdoctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Dr. Clare Gibson completed her Ph.D. in clinical psychology at the University of North Carolina at Chapel Hill where her training and research focused on social cognitive processes in schizophrenia and psychosocial interventions for individuals with serious mental illness. She completed her predoctoral clinical internship at the VAMHCS/University of Maryland Internship Consortium in the serious mental illness (SMI) track. Dr. Gibson then went on to complete a one year postdoctoral fellowship in VA's Interprofessional Fellowship Program in Psychosocial Rehabilitation and Recovery (PSR) at VA Connecticut Health Care System (the Paul Errera Community Care Center) & Yale School of Medicine. Dr. Gibson's interests are in psychosocial treatments for SMI and factors related to recovery particularly internalized stigma. Her professional interests include integrating recovery into mental health systems and self-care for mental health professionals.

Trauma Recovery Program (Outpatient Program): Posttraumatic Stress Disorder Clinical Team & Returning Veterans Engagement and Trauma Services

Patient Population

The TRP outpatient services in Baltimore consist of a specialized PTSD clinic (PCT) and the Returning Veterans Engagement and Trauma Services (R-VETS) Program. The PCT serves both male and female Veterans with a principal diagnosis of PTSD related to a variety of traumatic experiences, including combat, Military Sexual Trauma (MST), and childhood abuse. Many patients in the PCT have other co-occurring diagnoses and are active in treatment in other areas of mental health (e.g., Substance Abuse Treatment Program, Psychosocial Rehabilitation and Recovery Center, Mental Health Clinic). Our patient population is ethnically and racially diverse, with over 50% of patients of African-American descent. Approximately half of the patients seen in the PCT are those service members recently returning from Operations Iraqi Freedom and Enduring Freedom. We also provide a full range of clinical services for Veterans seeking services for MST.

The R-VETS program focuses specifically on providing mental health treatment to recently returning veterans who have experienced military-related trauma. R-VETS clinicians provide a variety of time-limited, empirically supported treatments to address symptoms of trauma/stressor related disorders, including adjustment disorders.

Assessments, Treatments, & Supervision

Interns will participate in the PTSD Assessment Clinic, where he or she will conduct several intake interviews to learn gold standard methods for diagnosing PTSD. The intern will complete at least two comprehensive PTSD assessments using structured interviews, objective measures of psychopathology, and standardized self-report instruments. Comprehensive assessment skills for this rotation may include training and supervision in the use of the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers *et al.*, 2013), the Anxiety Disorders Interview Schedule-5 (ADIS-5; Brown & Barlow, 2014), the PTSD Checklist for DSM-5 (PCL-5; Weathers *et al.*, 2013), the Mississippi Scale for Combat-Related PTSD (MISS; Keane *et al.*, 1988), the Minnesota Multiphasic Personality Inventory-2-RF (Ben-Porath, 2012), and the Personality Assessment Inventory (PAI; Morey, 2007).

The rotation will consist of core training experiences involving outpatient evidence based treatments for PTSD in both individual and group formats. We are fortunate to have multiple supervisors who are also consultants and/or trainers for our VA National Roll Out Trainings in CPT and PE. Interns can elect to focus on the implementation of either Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) with both individual patients, as well as in group psychotherapy. Interns also have the opportunity to learn Cognitive Behavioral Therapy for Depression (CBT-D), Cognitive Behavioral Therapy for Substance Use Disorder (CBT-SUD), Cognitive Behavioral Therapy for Insomnia (CBT-I), Motivational Interviewing (MI), Acceptance and Commitment Therapy for PTSD (ACT), Stress Inoculation Training (SIT), Seeking Safety, Dialectical Behavior Therapy (DBT), Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) and Skills Training in Affective and Interpersonal Regulation (STAIR). Elective experiences and minor rotations will be selected to round out the training plan for each intern.

The patient load will include two to four individual psychotherapy patients in addition to co-leading one to two outpatient groups. Interns will also conduct both brief unstructured interviews and comprehensive psychological assessments in the PTSD Assessment Clinic, to meet the Consortium requirements for assessment. Interns will receive at least two hours of individual supervision each week with a clinical psychologist listed below in order to review cases, provide further assessment and intervention training, and establish concrete treatment plans for group and individual patients. Additional supervision will be provided by other TRP staff psychologists, with several additional opportunities for group supervision available each week. Supervisors in the PTSD Clinical Team frequently highly value the use of audio and visual

recordings in supervision, and often use this method to assist in guidance in the implementation of evidence based treatments for PTSD.

Interns will participate in a number of training opportunities during the rotation, including monthly didactics, interdisciplinary treatment team meetings, and EBP consultation group. Interns who match with the Trauma Recovery Program (APPIC # 134719) often participate in a three-day Cognitive Processing Therapy training, with six months of consultation, from a VA national rollout trainer. Monthly didactic seminars will focus on the applied learning and practice of empirically supported treatments, assessment, administration, research and professional development (e.g., supervision) within the field of trauma work (See below for the 2015-2016 seminar schedule). An EBP consultation groups focused on the delivery of Prolonged Exposure and Cognitive Processing Therapy are also offered to trainees at all levels. Finally, the TRP has an extensive library of resources, including articles, manuals, and training videos that are available to interns.

Supporting Literature

Exposure therapy (ET; Foa *et al.*, 1991; Keane *et al.*, 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Cognitive therapy (CT), Imagery Rehearsal Therapy (IRT) and Stress Inoculation Training (SIT) have consistently shown high rates of efficacy for symptoms reduction as well, and all four treatments have been adopted as best clinical practices by the VA/DoD Clinical Practice Guidelines (VA/DoD Clinical Practice Guideline, Management of Posttraumatic Stress, 2010). Additionally, the use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa *et al.*, 2000). Although there is limited evidence surrounding efficacious treatment for dual-diagnostic patients with PTSD and substance use disorders, the Seeking Safety protocol (Najavits, 2002) has demonstrated promising longitudinal outcome data. While preliminary studies were limited to small sample sizes, and few addressed Veteran populations, more recent studies include larger samples and a variety of Veteran populations. Coping skills that are part of the Seeking Safety program are similar in content to anxiety management training and make an important link between PTSD and substance abuse/dependence.

In addition to the above-mentioned interventions, interns will be learning specific coping skills from Dialectical Behavior Therapy (DBT), which was originally designed for the treatment of borderline personality disorder but which can be applied to other patient populations (Linehan, 1993); principles of Acceptance and Commitment Therapy (ACT) as it applies to PTSD (Batten, Orsillo, & Walser, 2005; Hayes *et al.*, 1999); relaxation procedures, including progressive muscle relaxation and guided imagery; and other cognitive-behavioral approaches, including skills such as cognitive reframing and behavioral activation (Foa *et al.*, 2000).

Related to PTSD assessment, the CAPS has been shown to have excellent reliability and validity (convergent and discriminative validity) within trauma populations; it is considered the “gold standard” of interviews for PTSD (Weathers *et al.*, 2001). The PCL (e.g., Ruggiero *et al.*, 2003) and MISS (e.g., Norris *et al.*, 1996), both symptom self-report measures, have demonstrated utility in the assessment and diagnosis of PTSD, with good evidence for reliability and validity. Finally, the BDI and BAI are commonly used self-report measures that involve a general assessment of depressive and anxiety symptoms, useful as adjunct data in the comprehensive assessments of Veterans and for detection of possible co-occurring diagnoses. A comprehensive review of assessment procedures for trauma and PTSD can be found in *Assessing Psychological Trauma and PTSD* (Wilson & Keane, 2004).

Supervisors' Training & Experience

Interns' individual therapy will be supervised by one of the psychologists in the Trauma Recovery Program. The TRP staff has received extensive training in the use of exposure therapy and other above-mentioned interventions through graduate school education, internship training, postdoctoral training, and

specific workshops and training experiences that have enhanced their knowledge and expertise in the treatment of PTSD. Trauma psychologists will conduct one hour of peer consultation per week to maintain proficiency in evidence-based practices for PTSD.

Many of our current staff members have completed VA National Rollout Trainings in evidence based treatment and we are fortunate to have several national consultants and trainers. Among our current staff, we have certified consultants/trainers for the VA National Rollout Trainings of CPT, PE, CBT-Depression, and CBT-Substance Use Disorder.

Melissa Decker Barone, Psy.D. is the Director of the Postdoctoral Fellowship, and a Staff Psychologist in the PTSD Outpatient Team. She served as the Director of Training for the VAMHCS/UMB Psychology Internship Consortium from 2010-2015. She completed a psychology internship and postdoctoral fellowship in the Trauma Recovery Program at the VA Maryland Health Care System. She received supervision and training in empirically supported treatments for PTSD, as well as co-morbid PTSD and substance use, medical illness, and health behavior change. She has trained with Drs. Foa and Hembree to become a certified Prolonged Exposure consultant for the VA National Rollout Trainings. Dr. Barone has received training in Acceptance and Commitment Therapy (ACT), CPT, PE and DBT over the course of her graduate studies, and her doctoral dissertation investigated the role of worry in experiential avoidance. Her research interests include treatment outcome research for empirically supported treatments for PTSD, as well as the relationship between PTSD and comorbid health concerns. Dr. Barone was honored to be the recipient of the Outstanding Supervisor Award, awarded by the 2009-2010 VA/UMB Internship Consortium class, and Outstanding Director of Training in 2014.

Dave O'Connor, Ph.D. earned his graduate degree in Clinical Psychology at the Florida State University in Tallahassee Florida. He completed his internship at the Baltimore VAMHCS in 2002 with specialized training in the assessment and treatment of substance use disorders (SUD), neuropsychological assessment, and medical psychology. Dr. O'Connor was hired here after internship and provided general assessment, individual and group SUD treatment, and student training in the Opiate Agonist Treatment Program. During this work he developed an interest in the treatment of co-morbid SUD and PTSD and was very excited in 2009 to accept the position of Addiction Psychologist assigned to the Trauma Recovery Program in which, he focuses on providing care to this dual diagnosis population. Dr. O'Connor has received training in Motivational Enhancement, Prolonged Exposure, Cognitive Processing Therapy, and Relapse Prevention. Provision of and training in psychological assessment has always been one of Dr. O'Connor's areas of interest and he served on the Training Committee as Assessment Coordinator for the VA/UMB Internship Consortium from 2009-2015. He was highly gratified to be the recipient of the Outstanding Supervisor Award, awarded by the 2008-2009 VA/UMB Internship Consortium class.

Erin Romero, Ph.D. received her doctoral degree from Northwestern University Feinberg School of Medicine, Department of Psychiatry and Behavioral Sciences, Division of Psychology. She completed a psychology predoctoral internship at the VA Maryland Health Care System (VAMHC) and obtained specialized training in substance use, serious mental illness, and PTSD. She received further specialized training in PTSD during her integrated postdoctoral fellowship in traumatic brain injury and PTSD in returning Veterans at the VAMHC. Dr. Romero has received training in a variety of treatment models, including Motivational Interviewing, Acceptance and Commitment Therapy, Prolonged Exposure Therapy, Cognitive Processing Therapy, Virtual Reality Exposure Treatment, Seeking Safety, Dialectical Behavior Therapy, Wellness Recovery Action Planning, and Social Skills Training. Dr. Romero's research has focused on racial/ethnic health disparities. Her research on the mental health needs and HIV/AIDS risk behaviors of delinquent youth has resulted in multiple peer-reviewed publications and conference presentations. Dr. Romero has increasingly become interested in program evaluation and in barriers to treatment in returning Veterans. Dr. Romero is the Trauma Recovery Program Coordinator.

Erika White, Ph.D. completed her graduate education at Saint Louis University. She completed a pre-doctoral internship at the Washington, D.C. VAMC and a postdoctoral fellowship in trauma at the Pittsburgh VAMC. Her dissertation research focused on the effects of racial microaggressions and colorblindness on the working alliance of cross-racial counseling dyads. Dr. White is trained in Cognitive Processing Therapy and Prolonged Exposure. In August 2011, Dr. White was hired as a staff psychologist in the Trauma Recovery Program (TRP) at the Baltimore VAMC. Dr. White joined the Training Committee for the VAMHCS/UM Psychology Internship Consortium in 2012. In 2013, Dr. White assumed the role of Team Leader in the PTSD Clinical Team (PCT). In this role, she serves as coordinator for the PTSD Assessment Clinic, manages referrals for the PCT, and conducts treatment planning sessions with Veterans. Also in 2013, Dr. White was ecstatic to be selected as the Outstanding Supervisor of the Year by the intern class.

Elizabeth Malouf, Ph.D. completed her graduate education at George Mason University where she completed research and clinical training focused on substance use disorder (SUD). Her dissertation research focused on the relationship between substance use disorder and constructs related to impulsivity and emotion regulation. She completed a psychology pre-doctoral internship at the VA Maryland Health Care System (VAMHC) and obtained specialized training in substance use and PTSD. She received additional post-doctoral training in residential treatment for co-morbid PTSD/SUD through VAMHCS's postdoctoral fellowship in PTSD in returning Veterans. Dr. Malouf has training in Cognitive Processing Therapy, Prolonged Exposure, Motivational Interviewing and Acceptance and Commitment Therapy. In April 2015, Dr. Malouf was hired as a staff psychologist in the Trauma Recovery Program (TRP) at the Baltimore VAMC. Currently, Dr. Malouf is serving as program coordinator for the R-VETS program.

Christine Calmes, Ph.D. received her doctorate from the State University of New York-Buffalo and completed her pre-doctoral internship at the University of Maryland/VA Maryland Healthcare System (VAMHCS) consortium through the VA serious mental illness track. She completed one year of a post-doctoral fellowship through the MIRECC prior to taking a staff psychologist position in the Psychosocial Rehabilitation and Recovery Center (PRRC) at both Baltimore and Perry Point VA's. Several years ago, Dr. Calmes transitioned to a staff psychologist position in the Trauma Recovery Program (TRP) and has worked at the Perry Point and Baltimore VA TRP programs. Dr. Calmes serves as the Military Sexual Trauma Coordinator (MST) for the VA Maryland Healthcare System. Given her training and clinical experiences, Dr. Calmes has a special interest in treating Veterans with PTSD and comorbid serious mental illness, as well as Veterans with MST. Dr. Calmes primarily provides trauma-focused interventions, including Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) to Veterans. Dr. Calmes is a VA provider of Cognitive Processing Therapy (CPT), Motivational Interviewing (MI), Interpersonal Psychotherapy (IPT) for depression, and Cognitive Behavioral Therapy for Insomnia (CBT-I).

Perry Point VA Medical Center

Gero-neuropsychology – Community Living Center

Patient Population

The primary training site for interns is the community living center (CLC) at the Perry Point VAMC. Residents are males, 55 and older, who have varied ethnic and racial backgrounds with the majority being Caucasian and African American. Interns would occasionally have an opportunity to provide services to some younger residents (twenty-five to fifty-years old). A majority of the residents present with mild to severe cognitive impairment secondary to a variety of conditions, including degenerative neurological disease, cerebrovascular disease, metabolic conditions, nutritional deficiencies and traumatic brain injury. In addition, approximately half of the residents have a history of serious and chronic psychiatric conditions in addition to their medical issues. The types of co-existing psychiatric problems include

depression, anxiety, PTSD, schizophrenia, schizoaffective disorder, bipolar disorder, and substance use disorder. Other psychological problems that are often presented include grief and bereavement, pain disorder and adjustment disorders. The intern may have the opportunity to work with residents who have terminal illnesses and/or their families.

Assessments, Treatments, & Supervision

During the CLC gero-neuropsychology rotation, interns will function as an integral part of a medical inpatient, inter-disciplinary team (IDT), which includes the attending physician, social worker, chaplain, occupational and recreational therapist and nursing staff. In this role, the intern will also provide support for the CLC cultural transformation change process by providing consultation and in-service training to unit staff and by participating in activities to create a home-like atmosphere in the CLC neighborhoods (i.e., units). The intern will be expected to attend weekly IDT meetings, address consults for assessments as requested by the attending physician, carry a caseload of residents for individual psychotherapy and provide consultation to the IDT and nursing staff for residents who present with challenging and disruptive behaviors.

Interns will conduct cognitive and mood screenings for a minimum of twelve residents to assist in making recommendations for additional assessment and/or mental health intervention. These cognitive and mood screenings will consist of a formal mental status examination (e.g, MMSE, SLUMS, Mini-cog), the Clock Drawing Test, the Geriatric Depression Scale –Short-Form and/or the VA clinical reminder screening tools. In addition, it is anticipated that interns will conduct more in depth neuropsychological assessments for another four residents with an emphasis on evaluating their decision-making capacity and developing recommendations to assist with discharge planning. These neuropsychological assessments will utilize a flexible battery approach with the specific instruments being selected to most efficiently answer the referral question and which are most appropriate in consideration of the resident's age, language and sensory-motor functioning. The intern will be provided supervision and practice administering, scoring and interpreting the various instruments that are used while ensuring adherence to the APA Guidelines with regard to assessing older adults (APA 2008; Knight et.al., 1995).

Interns will also provide individual psychotherapy and/or behavioral intervention consultation to interdisciplinary treatment teams for six to eight residents addressing a variety of issues that may include psychosis, mood and anxiety disorders, adjustment disorders and bereavement as well as disruptive behaviors secondary to cognitive impairment. The psychotherapeutic intervention training/supervision will focus on case conceptualization and treatment utilizing a cognitive-behavioral model. Specifically, interns will be exposed to the CBT literature addressing anxiety, depression and pain management as well as the application of this approach to working with older adults and in long-term care environments (Gallagher-Thompson and Thompson 2009; Knight et.al., 1995; Laidlaw, et al 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, the intern will provide both formal and informal consultation services to the IDT and nursing staff to assist in the identification and implementation of behavioral/environmental interventions in order to address challenging and disruptive behaviors being displayed by residents (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Meeks & Teri, 2004; Nordhus et al., 1998). The PPVAMC is one of the STAR-VA pilot sites for implementation of an evidence-based approach to addressing disruptive behaviors secondary to dementia. The intern will be provided training and gain experience in implementing the STAR-VA approach to managing challenging behaviors.

Interns may choose either a major or minor rotation in CLC gero-neuropsychology as is consistent with their level of career interest. The intern will be provided a minimum of two hours of face-to-face individual supervision. However, it is anticipated that additional supervision will be provided, as needed, based on the intern's level of experience.

Supporting Literature

Long-term care settings are currently undergoing a cultural transformation designed to transition the nursing home care environment from that of an institutionalized medical model to a more home-like environment that is focused on client-centered service delivery (Baker, 2007; Thomas, 2007). Psychologists can play a pivotal role in supporting this change process through direct services to residents as well as by providing indirect support to long-term care staff (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Knight et al., 1995; Nordhus et al., 1998). Specifically, individual cognitive and behavioral interventions have demonstrated efficacy in addressing the psychiatric issues which are often presented in long-term care settings, such as mood disorders, depression, anxiety, and pain management (Gallagher-Thompson and Thompson 2009; Karel et al., 2002; Knight et al., 1995; Laidlaw, et al, 2003; Meeks & Depp, 2003; Meeks & Teri, 2004). In addition, literature has shown that the provision of proactive behavioral and environmental mental health services to residents with dementia can be effective in addressing challenging and disruptive behaviors (Attix and Welsh-Bohmer, 2006; Conn et al., 2007; Nordhus et al., 1998). As a result, the reliance on psychotropic medications can be reduced; thus decreasing the risk of detrimental side effects, including shortened life span (Knight et al., 1995). The use of neuropsychological assessment with the elderly as applied to decision-making capacity and discharge planning is growing (APA 2008; Attix and Welsh-Bohmer, 2006). Interns will be encouraged to gain familiarity with the literature addressing differential diagnosis and clinical and neuropsychological presentations of delirium, psychiatric disorders, mild cognitive impairment and various dementia syndromes (APA, 2008; Attix & Welsh-Bohmer 2006; Lezak et al., 2004; Ricker, 2004; Storandt & VandenBos, 1994).

Supervisor's Training and Experience

Dr. Jodi L. French earned her doctorate in clinical psychology from the Virginia Consortium for Clinical Psychology in 1991. She completed a major rotation in geroneuropsychology during her predoctoral internship at the Perry Point VAMC, which she completed in 1990. Dr. French also completed a two-year postdoctoral residency in clinical neuropsychology at the Fielding University in 1998. In addition, she worked as a consultant psychologist to community nursing homes and assisted living facilities in Virginia and Florida from 1995 to 1998. Since then, Dr. French has provided outpatient mental health services to aging adults and their families and caregivers in a private practice setting. In May 2008, she was appointed to the newly created CLC Clinical Psychologist position for the Perry Point VAMC and has been providing services to over 100 CLC residents living in at least four different long-term care neighborhoods (units). In addition, she has received training in the evidenced-based STAR-VA approach for addressing challenging and disruptive behaviors due to dementia that are displayed by residents in community living centers. Dr. French has specialized Neuropsychology privileges and has conducted outpatient neuropsychological assessments in a private practice setting since 1998.

Geropsychology

Patient Population and Setting

The primary training site for interns is the Perry Point 23B (i.e. Geriatric Extended Care inpatient rehabilitation unit). Patients on this unit tend to have multiple, chronic medical problems and many comorbid or contributing psychological dysfunction. Interns attend weekly treatment team meetings for treatment planning and case review. Interns will be assigned identified cases for treatment, consult with the treatment team on management of behavioral problems in the medical context, provide formal psychological and/or neuropsychological screening evaluation when indicated, and generally function as a team member on this unit. The intern will also receive referrals through our mental health clinic for outpatient psychotherapy for elderly patients so that the intern gains experience in longer-term therapy. Most patients are 65+, male, and approximately two-thirds are European-American, although occasionally interns would work with younger and/or female patients. Presenting problems include affective and adjustment disorders, co-morbid substance abuse issues, previously undiagnosed Axis II

spectrum issues, and dementias. The intern may have the opportunity to work with patients with terminal illnesses or who are at risk for sudden death.

Assessments, Treatments, & Supervision

Interns will be provided with training/supervision in case conceptualization and treatment in an Interpersonal/Sullivanian model. This treatment approach also relies on Erikson's life-span developmental theories and Butler's work on Life Review treatment for the elderly as theoretical underpinnings. Similarities and differences with Interpersonal Psychotherapy (IPT) (Klerman et al., 1984) are highlighted. Treatments are usually time limited (less than 15 sessions) and most cases are concluded prior to the intern's completion of the rotation. If not already acquainted, interns are introduced to the relevant Clinical Geropsychology and Neuropsychology of Aging literatures, as well as emerging practice guidelines for working with older adults (e.g. Interdivisional Task Force on Practice in Clinical Geropsychology, APA, 2004; La Rue, 1992; Molinari, et al., 2003).

In this form of treatment, there is a de-emphasis on predetermined interventions targeted only at symptom reduction, and a focus on assisting the patient in gaining greater understanding of rigid, maladaptive patterns of coping. These patterns become evident in the history, in interactions with other staff and patients, and, most usefully, in the treatment relationship with the intern therapist. Supervision is used to help the intern identify these salient aspects of the patient's presentation in sessions and how to help the patient utilize growing insight to elect changes in his/her relations with others.

The working alliance/relationship with the patient is seen as the key reparative element in psychotherapy (e.g. Stiles et al., 1998; Norcross and Wampold, 2011). Interns make audio recordings of all assessment and treatment contacts for review during supervision. Supervision has a process orientation with an emphasis on the intern's growing awareness of her/his interpersonal impact, perceptions/expectations about aging, in addition to acquisition of case conceptualization and treatment application skills, knowledge of how the patient's aging affects the treatment process, etc.

Interns will typically complete 6 neurocognitive screenings and/or personality assessments during a rotation. Focused neurocognitive evaluations are conducted using a battery tailored to the referral question. As needed supervision, practice administration with the battery, and background reading on the various dementias augments the intern's other training. Personality assessment, when needed, is undertaken using standard psychometric instruments such as the Personality Assessment Inventory (Morey, 1991) or MCMI-IV. Interpersonal diagnosis is also conceptualized via circumplex models of interpersonal behavior (e.g., Benjamin, 1993; Orford, 1986).

Interns begin the rotation with many different backgrounds, professional interests, and degrees of preparation in clinical geropsychology. Major and minor rotations are available, both for interns planning a career in geropsychology and those just seeking to gain "some experience" with this population.

A typical week's schedule would include three days at the Perry Point site. A minimum of two hours of supervision will be scheduled but often, especially early in the rotation, unscheduled supervision occurs on specific issues. Cases will be assigned first on their potential to add to the intern's experience and skill as a therapist and only secondarily for 'workload'. Early in the rotation, many interns spend considerable time reading core materials re: the Interpersonal/Sullivanian approach to treatment.

Supervisor's Training and Experience

Scott N. Jones received his Ph.D. from Miami University (Ohio) in Clinical Psychology in 1989. He earned a graduate certificate of training in Gerontology from the Scripps Foundation Gerontology Center

while at Miami. He completed an NIMH-funded predoctoral internship in Clinical Geropsychology at the Hutchings Psychiatric Center in Syracuse, NY in 1987-88. He then helped to develop and was the first director of a Geriatric Day Hospital Program at Bangor Mental Health Institute in Bangor, Maine. He has been the staff Geropsychologist and Neuropsychologist at the VA Maryland Health Care System, Perry Point Division since 1991. He has provided services on various nursing home units, in the mental health clinic and on a subacute rehabilitation unit for elders. Dr. Jones earned a Specialist/Diplomate from the American Board of Geropsychology in 2014. His research interests include Interpersonal psychotherapy, life span development, Neuropsychology of the dementias, and philosophy of science issues.

Mental Health Clinic

Patient Population

The mental health clinic serves approximately 4,000 Veterans in a given year, the majority of whom receive medication management. The average age of Veterans treated is in the early 40's. Veterans receive treatment for a variety of mental health conditions including major depression, anxiety disorders (i.e., PTSD), interpersonal relationship difficulties, bipolar disorder and dual diagnosis. A portion of these Veterans may also present with characterological issues.

Assessment, Treatment and Supervision

Training in this rotation will focus on competency as a generalist in an outpatient practice. Core skills will include assessment utilizing structured diagnostic interviews, bio-data, and objective psychological tests, individual psychotherapy and group psychotherapy using Cognitive-Behavioral, Acceptance and Commitment Therapy, and Existential formulations, as well as group psychoeducation. Interns will have the opportunity to conduct brief psychosocial assessments in the Mental Health Assessment and Referral Clinic (MHARC), allowing the opportunity to integrate data from an unstructured interview, chart review, and brief symptom assessment measures to assist in initial case formulation for treatment and consultation to other mental health disciplines. In addition, the intern will complete at least two comprehensive integrated psychological assessments. Primary psychological instruments used will include brief structured interviews (such as the SCID, MINI, and CAPS) and objective psychometric measures (the PAI, MMPI-2, NEO-PI-3, and MCMI-III). There is also the opportunity to obtain experience using symptom validity measures. Assessment referral questions typically address differential diagnosis for treatment planning.

The intern will carry a clinical caseload of 5-7 Veterans for individual psychotherapy. Ideally this will include following several cases from intake to resolution, including assessment, case formulation and a course of time-limited evidence-based psychotherapy. Psychotherapy training will emphasize evidence-based cognitive and behavioral techniques that have broad application across a number of diagnoses, including depression, anxiety, and emotion dysregulation. Treatment modalities include Cognitive-Behavioral therapy (CBT), Acceptance and Commitment Therapy (ACT), Existential-Humanistic Therapy and Skills Training Affective and Interpersonal Regulation (STAIR). Interns interested in obtaining more experience with Veterans with PTSD may (depending on availability) have the opportunity to provide individual assessment and therapy to Veterans with symptoms of PTSD, including evidence-based trauma therapies, such as Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Exposure Relaxation and Re-scripting Treatment (ERRT) for nightmares. Interns will also be involved in co-leading or leading at least two psychotherapy or psychoeducation groups through the Perry Point campus-wide Recovery Center (see description below) and/or general Mental Health Clinic.

Interns will have two individual, hour-long supervision sessions per week to discuss assessment cases, case conceptualizations, documentation, and individual psychotherapy cases. Additionally, interns will have the opportunity to discuss treatment modalities and to ask questions about professional development during supervision. Supervisors will also provide "on the spot" feedback during groups that the intern co-leads with the supervisor. The intern is always welcome to pop in with questions and/or concerns

between supervision sessions. The general approach to supervision is collaborative, with the goal of supervision to ensure that the intern is getting the training experience that he/she desires.

Supporting Literature

Cognitive-Behavioral Therapy (CBT) is a time-limited, evidence-based intervention for depression, insomnia, and anxiety disorders, including social anxiety, generalized anxiety disorder, and panic disorder (Butler et al., 2006; Chambless et al., 2001; Gloaguen et al., 1998; Moran et al., 2006). Interns will have an opportunity to co-lead a group based on the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2010), a CBT treatment model that approaches emotional disorders from a shared phenomenology.

Acceptance and Commitment Therapy (ACT) is a third-wave therapy designed to help people increase their psychological flexibility and change their relationship with unpleasant experiences in order to move closer to their values (Hayes et al., 1999). ACT combines acceptance, cognitive defusion, and mindfulness principles to help people to change their relationship with thoughts. ACT has been shown to be an effective treatment for depression, psychosis, substance use disorders, and chronic pain (Hayes et al., 2004).

Existential–Humanistic Therapy is concerned with human potential and the individual's unique personal experience. It views psychological problems as the result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live. It emphasizes not only the concepts of freedom and responsibility, but also experiential reflection. The goal of this therapy is to help clients free themselves from self-imposed limitations and come to a deeper understanding of their authentic life goals, versus those imposed by others or by a rigid sense of self. Consequently, interventions are aimed at increasing client self-awareness and self-understanding. This approach is applicable in a wide array of settings and diagnostic populations (SAMHSA –TIP 34, 1999; Schneider and Krug, 2017).

With regard to EBPs for PTSD, exposure therapy (Foa et al., 1991; Keane et al., 1989) has been consistently demonstrated as an effective treatment for addressing specific traumatic memories; this approach has been endorsed by the Division 12 Task Force as an efficacious treatment for PTSD. Additionally, Cognitive Processing Therapy (CPT) has also been shown to be an efficacious treatment for Veterans with PTSD (Monson et al., 2006). Exposure Relaxation and Re-scripting Treatment (ERRT) has been shown to be effective in treating nightmares related to PTSD (Davis, 2009). The use of anxiety management training has been empirically supported in the PTSD and other anxiety research literature (Foa et al., 2000).

Supervisor's Training and Experience

Dr. Poet earned his doctorate from La Salle University in Philadelphia, PA. He completed his pre-doctoral internship at St. Elizabeth's Hospital in Washington, DC. He is a staff Psychologist in the Perry Point Outpatient Mental Health Clinic, where he conducts psychodiagnostic evaluations and provides evidence-based individual and group-based psychotherapy with Veterans who present for a wide range of Mental Health issues. Dr. Poet practices from a Cognitive-Behavioral orientation with a focus on Acceptance and Commitment Therapy (ACT). He is a VA certified provider of Acceptance and Commitment Therapy (ACT) for Depression, Motivational Interviewing (MI) for Behavior Change, Interpersonal Psychotherapy (IPT) for Depression, Cognitive Behavioral Therapy for Chronic Pain (CBT-CP), and Prolonged Exposure (PE) for PTSD.

Dr. Greer completed his Ph.D. at Fielding University and his pre-doctoral internship at the Devereux Foundation in Pennsylvania. He is a staff psychologist in the Perry Point Outpatient Mental Health Clinic and provides both individual and group therapy from an Existential-Humanistic perspective. He also utilizes Cognitive Processing Therapy (CPT), Motivational Interviewing (MI), and Exposure Relaxation

and Re-scripting Treatment (ERRT) in individual therapy and leads weekly groups in Motivational Enhancement Therapy for Substance Use disorders and Conflict Resolution through dynamic mindfulness practice (Aikido).

Primary Care-Mental Health Integration (PCMHI) Rotation – Perry Point

Patient Population

The primary care clinic in Perry Point is a small, rural clinic, with approximately 6 primary care providers serving 4,800 Veterans. The average age of Veterans in this clinic is 60 and the majority (80%) are male. Veterans receive care within Patient Aligned Care Teams (PACT), which are patient-centered medical homes that are structured to provide coordinated, accessible, and patient-centered healthcare. As all PCMHI providers do, interns will function as integrated members of the PACT by providing consultation to primary care providers and the PACT teams, having availability to see patients on the day of their primary care visit, and attending and contributing to PACT team meetings.

Assessments, Treatments, & Supervision

Interns will have the opportunity to provide brief (30 min.), targeted behavioral health assessments for Veterans who are referred by their primary care team. The purpose of assessments in PCMHI is to clarify the presenting problem and triage the Veteran to the appropriate treatment setting. Veterans who are appropriate for treatment in PCMHI include those with common, uncomplicated presenting problems, such as depression, anxiety, tobacco use, obesity, adjustment issues, adherence problems, enhancing health behaviors, uncomplicated grief, and chronic pain. Most patients presenting to PCMHI can be treated/managed within this setting. Interns will learn to tailor assessments to the particular Veteran and his/her presenting problem. Depending on patient presentation and the nature of the referral, assessments may include administration of brief measures, such as the Patient Health Questionnaire-9 (PHQ-9), Posttraumatic Stress Disorder Checklist (PCL), Generalized Anxiety Disorder-7 item scale (GAD-7), Montreal Cognitive Assessment (MoCA). Interns may also have the opportunity to complete pre-transplant evaluations on this rotation.

Interns will have availability to see both scheduled patients and walk-in patients (warm hand offs) from primary care providers. Patients who are typically referred to PCMHI include those with depression, substance use disorder, PTSD, anxiety, tobacco use disorders, obesity, diabetes, chronic pain, and insomnia. Treatment in the primary care setting is brief (up to 6, 30 minute sessions) and evidence-based. Interns will utilize a wide variety of brief interventions, including behavioral activation, motivational interviewing, relaxation training, and brief CBT. Interns may have the opportunity to provide individual as well as group treatments. Group opportunities may include diabetes management group, weight management group (MOVE), pain school, depression group, and mindfulness-based stress reduction for medical conditions.

Supporting Literature

Integrated Primary Care: Integrated care can increase access to mental health care, reduce the burden on specialty mental health clinics, and modify willingness of primary care providers to address mental health concerns (Brawer, Martielli, Pye, Manwaring, & Tierney, 2010; Felker et al., 2004). It may also serve to reduce the stigma associated with mental health treatment, as a higher number of patients engage in treatment when it is integrated into primary care versus when it is delivered in specialty mental health (Bartels, 2004). Primary care providers have positive perceptions of integrated care, with the majority reporting that integrated care leads to better communication between primary care providers and mental health providers, less stigma, better coordination of care, and better management of depression, anxiety, and alcohol problems (Gallo et al, 2004).

Brief Interventions: Interventions utilized in this setting are brief and evidence-based. When designing interventions, PCMH clinicians take into consideration the best available evidence along with patient characteristics and clinical expertise to develop a treatment plan that is grounded in research and also tailored to each individual Veteran's specific needs. Given the breadth of patients seen in primary care, only a review of some of the most common interventions will be discussed. Examples of common interventions include behavioral activation, brief CBT, and motivational interviewing.

Brief (4 session) primary-care based behavioral activation has been shown to reduce symptoms of both anxiety and depression in Veterans (Gros & Haren, 2011). Brief CBT has been shown to be effective in the treatment of depression and anxiety (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Nieuwsma, 2012). A recent Cochrane review found that CBT for pain has positive effects on disability, mood, and pain catastrophizing (Williams & Eccleston, 2012). Brief behavioral intervention has been shown to be effective in treating insomnia (Buysse, 2011). Finally, brief motivational interviewing has been shown to reduce risky drinking behavior (Brown et al., 2010).

Supervisor's Training & Experience

Dr. Schneider earned her doctorate in clinical psychology from La Salle University with a health psychology concentration. She focused on chronic pain, coping, and acceptance of pain during her graduate training. She completed her internship at the Miami VA Medical Center, with training in the psychological assessment and treatment of various geriatric and medical patient populations, including cancer, medical inpatient consultation and liaison, hospice/palliative care, chronic pain, and transplant. She then completed a one-year postdoctoral fellowship at Salem VA Medical Center, with a focus on primary care-mental health integration and behavioral medicine (chronic pain, diabetes, transplant, and bariatric surgery candidates). *Dr. Schneider's* career experiences have focused on chronic disease management, coping with chronic illness, health behavior changes, and chronic pain management. Outside of supervision with *Dr. Schneider*, interns will have a variety of learning opportunities that are relevant to the primary care setting and appropriate to the level of experience and specific interests of the intern. For example, interns may shadow PACT team members (nurses, primary care providers, dieticians), present health psychology topics to primary care providers at meetings, and become familiar with relevant literature on collaborative healthcare.

Residential Treatment Rotation Description

Patient Population

The patient population in residential treatment at the Perry Point VA includes a wide age range, from returning Iraq and Afghanistan veterans to Vietnam era veterans. Most patients are male but female veterans are represented as well. Patients vary diagnostically and may present with major depression disorder, bipolar disorder, anxiety disorders including PTSD, psychotic disorders, substance use disorders, and personality disorders and/or issues. Many of the patients grapple with homelessness, unemployment and other significant psychosocial stressors. In terms of severity, patients possess a level of functioning that is non-acute, though occasionally patients' symptomology increases while in residential treatment. Often patients struggle with outpatient psychotherapy engagement and a significant treatment goal is to help create a smooth step-down to a lower level of care in preparation for the completion of residential treatment.

Assessments, Treatments, and Supervision

Interns will have the opportunity to participate in both assessment and treatment interventions. Assessments pertain to the referral question posed and often have to do with diagnostic clarification, including understanding personality structure. Brief cognitive screens are also performed with some regularity. Resulting findings and recommendations are used to help staff guide the course of treatment

for patients. Interns will also be able to participate in Residential Screening Interviews, typically for one half day a week, where they serve as a panel member that helps determine if patients presenting in-person or via phone are appropriate candidates for a residential level of care and which program best suits their needs. Interns may have the opportunity to follow patients through several levels of care in their treatment, such as detoxification, acute psychiatry, sustained psychiatry, residential, aftercare, and outpatient treatment. Individual psychotherapy, process group, and psychoeducation group training experiences are also an integral part of the internship rotation; see below for program specific details. Exposure to families and couples interventions may also be available.

Each intern will receive two hours of individual supervision a week, which can be completed with one primary supervisor or two supervisors, depending on intern preference. Video and audio recordings of sessions may be reviewed, collaboratively. Flexibility exists with the number of days available for training in a residential treatment program. A major rotation is typically 3 to 4 days and a minor rotation is 1 day a week. An option exists to intern at 1 residential program the majority of the week and also spend 1 day at another of the residential programs.

Clinical Settings

Domiciliary Residential Rehabilitation and Treatment Program (DRRTP)

The DRRTP is a 30 bed residential treatment program providing services to homeless Veterans who seek housing and employment in the community. The DRRTP utilizes an employment-focused model with a strong therapeutic community, based on both peer and staff support. The ultimate goal is for Veterans to re-integrate into independent living in the community. The DRRTP residence is currently only partially open with 30 beds, with 17 additional beds to be available in the future; it is open to male and female Veterans. Veteran residents stay 4 to 6 months, on average. The DRRTP is focused on helping each Veteran meet his/her highest level of functioning. This often means gainful employment for most Veterans, though some pursue school, volunteering, or other means to feeling useful and productive. DRRTP staff includes individuals from a wide array of disciplines including psychology, social work, psychiatry, medical, occupational therapy, nursing, and recreational therapy. Together, these staff members form the treatment team who assist the Veterans in reaching their treatment goals.

Programming includes group and individual therapy, case management, job and housing searches, as well as participation in monthly treatment teams to review treatment goals and progress through the program. Current group therapy is focused on treating the typical presenting concerns of DRRTP residents, including both psychoeducational and process-oriented groups. Some of the current groups include Anger Management, Relating to Others (incorporating newly learned skills to past and current relationships), Stress Reduction (integrating Mindfulness-based and relaxation techniques/training), Problem Solving, Leisure Skills and Community Integration, Relapse Prevention, Spirituality, and Wellness (linking physical health to bio-psycho-social factors). Individual therapy is typically brief and solution-focused for presenting concerns such as anger management, relapse prevention, depression, anxiety, and grief. Assessments may also be a part of individual therapy, as clinically indicated.

Interns can expect to lead therapy groups, either existing groups or creating new groups, based on the needs of the resident population. Interns will also be able to carry a small caseload of individual therapy/assessment patients, provide case management, and assist with discharge planning. Interns are encouraged to work as a member of the DRRTP treatment team, including recommending and creating additional programming which may benefit our Veteran residents.

Supervisor's Training and Experience

Catherine Pilotte Mullins, Ph.D. Dr. Pilotte Mullins earned her doctorate in 2012 from Purdue University's Counseling Psychology program. She completed her pre-doctoral internship at the Syracuse VA Medical Center, completing rotations in Outpatient Mental Health, Outpatient Substance Abuse treatment, Health Psychology, and Psychosocial Rehabilitation and Recovery Center. As an intern she also received additional training in inpatient and outpatient assessment, Prolonged Exposure, and Cognitive Processing Therapy. Dr. Pilotte Mullins has additional clinical experience working in both residential and outpatient substance abuse settings, working with dually-diagnosed adolescents in a residential treatment center, and with college students with career-related concerns. She integrates client-centered, cognitive behavioral, and motivational interviewing approaches into her clinical work.

Psychosocial Residential Rehabilitation and Treatment Program (PRRTP), Serious Mental Illness Focus

The Perry Point PRRTP is a 71-bed voluntary residential program with a 90 – 100 day length of stay that offers Veterans with psychiatric disorders treatment focused on improved symptom management and community reintegration. The PRRTP provides a 24-hour therapeutic setting utilizing a milieu of peer and professional support with a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living. The PRRTP provides a safe environment for Veterans to work on mental health, substance use, and psychosocial needs until they are able to resume personally identified goals and roles in the community.

The treatment milieu utilizes the principles of Psychosocial Rehabilitation and Recovery to guide services provided to the Veterans receiving care. SAMHSA (2013) defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The guiding principles of recovery are strengths based and includes instillation of hope, person-driven care, and holistic treatment that utilizes the natural and community supports available to assist Veterans in achieving self-identified goals.

The treatment milieu on the PRRTP is designed to promote safety and recovery from mental health symptoms and substance use. The Veteran population includes men and women between the ages of twenty to eighty with a diversity of care needs, including mental health, physical care needs, and multiple psychosocial stressors. Diagnostically, Veterans present with all mental health symptoms, including Serious Mental Illness (SMI). This is an open unit designed to assist Veterans in learning skills to manage symptoms while increasing their level of independence in a supportive environment to move toward community reintegration. This is accomplished through the coordination of care across the continuum of services offered at the Perry Point Campus (e.g., Recovery Center, PRRC, Medical Care). A multidisciplinary treatment team approach is used, which includes active involvement by the Veteran to build on strengths.

The role of the Psychologist on the PRRTP includes acting in the role of Recovery Partner, coordinating care and completing disposition planning. This includes the provision of individual therapy, group therapy, patient education, family meetings, treatment team meetings and treatment planning, as well as psychological assessment. Due to the changing nature of the unit, the Psychologist must be flexible in creating treatment to meet the needs of the Veterans.

The intern will be fully integrated into the treatment milieu and the provision of services to the Veterans. They will learn the principles of psychosocial rehabilitation and practice those within the treatment milieu. They will provide individual and group therapy, complete psychological assessments and reports, and participate in treatment team meetings. Therapy approaches used with the Veterans are short-term evidence based interventions. These interventions may include, Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Seeking Safety, Illness Management and Recovery, Social Skills Training and Wellness Recovery Action Plans. The intern will have the opportunity to participate in

program development as we continue to transform the unit milieu to a recovery focus. The intern and supervising psychologist will work collaboratively to meet the self-identified goals of the intern during the rotation. The methods that may be used in supervision include audiotape, co-therapy, observation, case discussion, and review of completed assessments and reports.

Supporting Literature:

A recovery based model of treatment for those with a Serious Mental Illness diagnosis includes a combination of psychotropic medications and evidence based interventions designed to assist client's in learning symptom management skills, community living skills, and to identify meaningful community based roles they want to engage in. In addition, care needs to be provided with respect for patients preferences in intervention choice (LeVine, 2012). The first-line treatment for Schizophrenia is neuroleptic medication, although a majority of patients also benefit from the inclusion of psychosocial interventions (Lehman et al., 2003). These interventions include therapy, case management, and family psychoeducation (Lehman, et al. 2004). The treatment approach utilized on 364A is primarily Cognitive Behavioral Therapy. Cognitive Behavioral Therapy (CBT) is considered a short-term intervention designed to address mental health symptoms, reduce distress, and promote healthy behavioral responses in the here and now. CBT has demonstrated effectiveness in the treatment of Mood Disorders (Major Depressive Disorder and Bipolar Disorder); Anxiety Disorders (Panic Disorder, OCD, Specific Phobia, PTSD, GAD); Psychotic Disorders (Schizophrenia); and Substance Use Disorders, across age ranges (Leichsenring et. al., 2006). Cognitive Behavioral Therapy has demonstrated the "strongest evidence base" in the treatment of Schizophrenia (Dickerson & Lehman, 2006). In addition to CBT, Acceptance and Commitment Therapy is often utilized with the Veterans receiving care on 364A. ACT does not work on reducing symptoms, but instead focuses on how Veterans respond to symptoms that will allow for increased values-driven behavior (Bloy et al., 2011).

Supervisors Training and Experience:

Julie Rife-Freese, Psy.D. Dr. Rife-Freese completed her Psy.D. at Argosy University, Washington, DC Campus and her internship training at the Coatesville VAMC, with a focus on providing services to Veterans with an SMI diagnosis. Upon completion of her internship training she continued to work with Veterans diagnosed with a SMI on an inpatient psychiatric unit at the Coatesville VAMC. This role included working toward transforming the unit milieu to a recovery orientation through the implementation of psychosocial rehabilitation principles. Dr. Rife-Freese was a member of the Internship Training Committee at the Coatesville VAMC for 4-years and supervised interns in both inpatient and outpatient settings. Dr. Rife-Freese is a full time psychologist on Psychosocial Residential Rehabilitation Treatment Program (PRRTP).

Substance Abuse Residential Rehabilitation and Treatment Program (SARRTP)

The SARRTP is a 62-bed residential treatment program designed primarily to address substance use disorders. Issues with homelessness and unemployment are also common targets of treatment. Currently, the building is under construction; patient census is approximately 30. Staff offices, group rooms, and patient bedrooms reside in the renovated portion of the building. In addition to residents in the SARRTP, patients from the PRRTP and, occasionally from the community, join together during the daytime programming, referred to as the Intensive Outpatient Program (IOP). Approximately 10 patients at a time participate in the IOP. Daytime programming for SARRTP residents and IOP patients are synonymous and runs for 21 days. Length of stay in the SARRTP varies from 21 to 100 days. Aftercare groups also meet and some patients are followed in an outpatient basis in this way.

The content of the daytime programming takes the form of process and psychoeducational groups, drawing from four primary treatment modalities. Treatment approaches include 12-Step Facilitation,

Motivational Enhancement Therapy, Cognitive Behavior Therapy, and Mindfulness practice. Additionally, each week of programming centers around a particular theme, which are: Week 1: Gaining Clarity and Developing Compassion (Acceptance), Week 2: Change and, Week 3: Connections. Interns may select a particular treatment modality to focus on during the rotation or select experiences across approaches.

As an example of the day to day activities while in a 3 day a week rotation, the intern sees 4 patients for individual psychotherapy and light case management. If rotating Monday-Wednesday-Friday, the intern participates in all three process therapy groups offered during the week. The intern also partakes in 2-3 psychoeducational programs co-led by a psychologist or with staff from other disciplines. In addition to these activities, interns also develop and enhance their skills at operating on a multidisciplinary team and being a member of the milieu. The treatment team meets every day for morning report and to address patient issues that have arisen that would benefit from staffing. The treatment team and patients also divides up into four “squads” to help individualize care. Interns will participate in writing treatment plans that are developing during squad collaboration.

Supporting Literature

Motivational Enhancement Therapy, 12-Step Facilitation, and Cognitive Behavioral Therapy have all been found effective for the treatment of substance abuse disorders (NIAAA Project MATCH, 1996). Mindfulness based approaches to addiction also garnish empirical support, particularly for relapse prevention (Marlatt & Donovan, 2005). Problem-solving therapy helps to teach an individual to manage the negative effects of stressful life events (Nezu, Nezu, & D’Zurilla, 2013). Anger management for substance abuse and mental health clients (SAMHSA, 2013) teaches clients to identify cues to anger and offers strategies for avoiding anger outbursts and their negative effects.

Supervisor’s Training and Experience

Kathleen McGrath, Ph.D. Dr. McGrath earned her doctorate in Clinical Psychology with a specialization in Cognitive Behavioral Therapy (CBT) from Drexel University in 2012. She completed her pre-doctoral internship at the VA Maryland with rotations in the Addictions Treatment/Acceptance and Commitment Therapy (ACT) Program, the Psychosocial Rehabilitation & Recovery Center (Perry Point), Trauma Assessment, and the Trauma Recovery Program. She completed a post-doctoral fellowship in PTSD and Mental Health at VA Maine Medical Center with rotations in the PTSD (ACT) Intensive Outpatient Program, the PTSD Clinical Team, and Integrated Primary Care. Additional clinical experience includes serving as the Director of the Dialectical Behavior Therapy (DBT) program at the Center for Integrated Behavioral Health. She currently serves as a Staff Psychologist in the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) where she provides individual CBT, ACT, DBT, and motivational interviewing to veterans with substance use and co-occurring disorders, and facilitates DBT-based psychoeducational groups. She also has specialized training in Cognitive Processing Therapy, Prolonged Exposure, Exposure and Response Prevention, and Habit Reversal and Stimulus Control.

Perry Point Supplemental Training Opportunities

Psychosocial Rehabilitation and Recovery Center – Perry Point

Patient Population

The Perry Point Psychosocial Rehabilitation and Recovery Center (PRRC) serves Veterans with serious mental illness (SMI) including schizophrenia, affective disorders, and some severe forms of anxiety disorders. A portion of PRRC Veterans have a co-occurring substance use disorder which may also be a

focus of treatment. Veterans served by the PRRC typically experience a range of functional limitations. The majority of Veterans are male and ages range from 20s to 70s.

Assessments, Treatments, and Supervision

PRRCs represent one of VA's many efforts to implement the goals of the President's New Freedom Commission on Mental Health including the principle that mental health care should be individualized and recovery focused. As such, PRRCs offer a daily menu of treatment alternatives with sufficient variety to support meaningful choice. Veterans are encouraged to set personally relevant recovery goals and select the groups and classes that will assist them with meeting these goals. As part of these treatment choices PRRC's are tasked with providing evidence-based interventions designed for the SMI population.

The intern will receive training in the following SMI focused interventions: social skills training and cognitive behavior therapy (CBT). The latter delivered in either group based or individual formats. The intern will also co-lead Illness Management and Recovery (IMR) psychoeducation, co-occurring disorder groups and mindfulness based interventions. The intern will see 3-4 individual psychotherapy cases and co-lead groups with their supervisor. There will be additional opportunities to co-lead similar groups (anger management, co-occurring disorders etc.) through the Perry Point campus wide *Recovery Center* (see description below). In addition to delivering evidence based interventions the intern will provide case management to Veterans participating in PRRC. As part of case management interns will collaborate with Veterans in identifying personal recovery goals. These goals inform the Veteran's individualized treatment plan and how the program is tailored to their needs. The intern will also participate on the PRRC interdisciplinary treatment team. With regard to assessment, interns will have the opportunity to use standard psychological assessment measures such as the WAIS, WMS, PAI and MMPI as well as more brief screening instruments (e.g., RBANS) in order to inform treatment planning for certain cases. Finally, the PRRC rotation offers the intern the opportunity to learn about a recovery focused approach to mental health.

Supporting Literature

As reviewed above, the PRRC is tasked with delivering evidence based interventions for SMI. Social skills training, CBT, and treatments for co-occurring disorders among others are recommended interventions for schizophrenia (Dixon et al., 2010). There is strong support for use of social skills training for individuals with schizophrenia and related SMI (Kurtz & Mueser, 2008). This modality uses behaviorally-based instruction, modeling, rehearsal, corrective feedback, and positive reinforcement to teach a variety of interpersonal skills. Many Veterans served by the PRRC, while not in an acute phase of illness, still experience depressive and anxiety symptoms and have been able to learn and benefit from CBT strategies. The evidence base for CBT for depression and anxiety is substantial including support for use of group based CBT interventions. The evidence base for use of CBT for individuals with SMI is expanding and also includes group based interventions (Granholm, et al., 2005) and there is moderate meta-analytic support for the use of CBT for psychotic symptoms (Wykes et al., 2008). There is a high rate of substance use among individuals with SMI and individuals with co-occurring disorders should be offered substance abuse treatment tailored for SMI related impairments (Dixon et al., 2010). For these Veterans skills based, psychoeducation, and coping skills components of the Behavioral Treatment for Substance Abuse in Schizophrenia (Bellack et al., 2006) are provided. Finally, while the evidence base for Illness Management and Recovery (IMR) interventions is preliminary this psychoeducation and skills based group is well grounded in evidence based principles (Hasson Ohayon, 2007; Levitt et al., 2009). The importance of the recovery focus also warrants a brief comment. Recovery based services are not an evidence based practice per se but rather represent a paradigm shift in mental health care. Recovery has been defined by SAMHSA to include: hope, self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, and responsibility. As such, recovery is the context within which the above mentioned interventions are delivered and informs the manner in which, for example, treatment choices are presented and the way cases are conceptualized.

Supervisors' Training and Experience

Dr. Mary Gardner earned her Ph.D in Clinical Psychology from the University of Maryland, College Park, focusing on stress and coping as well as serious mental illness. She completed her internship through the MIRECC at the Perry Point VA Medical Center, unit 364A. In this setting she received training in diagnosis and treatment of serious mental illness, including token economy and social skills training. She participated in MIRECC-related research as well. Dr. Lambert accepted the position of unit psychologist upon completion of her internship, and remained in this position for the next 6 years. She then moved on to coordinate the Health Improvement Program at both the Baltimore and Perry Point sites for 2 years. In 2010 she was asked to lead the development of what later became known as the Perry Point Recovery Center. In this capacity she provides clinical services as well as administrative oversight to both the Recovery Center as well as the Perry Point PRRC.

The Recovery Center

The Mental Health Recovery Center is a recent VAMHCS clinical initiative implemented to increase access to, efficiency in, and satisfaction with mental health services at the Perry Point campus. In brief, the Recovery Center is designed to be a “one-stop shop” for multidisciplinary mental health psychoeducational and therapeutic services. Veterans from across the Perry Point campus (both inpatient and residential settings) and surrounding community are able to select from a “course catalog” of treatment groups and classes relevant to their personal recovery goals. Groups and classes include evidence based mental health interventions, skills based, wellness/recovery oriented and supportive therapy groups addressing a wide range of psychosocial issues that Veterans are faced with. These include for example, mood, anxiety, trauma, chronic pain, substance use, co-occurring medical conditions, TBI and other skills related (e.g., budgeting) and relationship issues. In addition to offering a comprehensive array of services, the Recovery Center also strives to make accommodations so that no Veteran is deemed “inappropriate” for services in order to maximize access to services. The rationale for this method of service delivery is to enhance the VAMHCS’ ability to provide a continuum of care designed to be more accessible and individualized for Veterans seeking mental health services.

As a point of clarification, the Recovery Center is not designed to replace specialized treatment programs such as, for example, substance use disorders and trauma but rather is an opportunity for Veterans to supplement this treatment with additional groups and classes. This arrangement enhances efficiency by removing the redundancy of offering multiple groups targeting the same problem (e.g., anger management) across programs and units. Also the Recovery Center is distinct from the PRRC in that it serves all Veterans regardless of diagnosis or functional impairment, whereas the PRRC is tasked with serving Veterans with severe mental illness and resulting functional impairment. However, Veterans enrolled in PRRC are not excluded from participating in Recovery Center groups as well.

Interns who select rotations at the Perry Point campus will have the opportunity, with input from their primary supervisor, to supplement their training with Recovery Center clinical activities. These opportunities include co-facilitating groups such as Seeking Safety, Sleep Hygiene, CBT for depression and anxiety, mindfulness meditation, Anger Management, and Chronic Illness Support Group. For particularly industrious interns there may also be opportunities to develop and implement (with supervisor support) a specific time limited group during their rotation.

For the interested intern there are also program evaluation and program development opportunities within the Recovery Center as well as in other Perry Point programs (e.g., PRRC). These include, for example, measuring Veteran satisfaction with services, needs assessment, evaluating outcomes, assessing program efficiency and related performance improvement activities. These are small scale and time limited clinically focused projects but are an opportunity to get ones’ hands dirty with real world data. Interns would have the opportunity to participate in several ongoing workgroups associated with the Recovery Center including a program evaluation and needs assessment workgroup or a clinical programming workgroup.

Loch Raven CBOC

Hospice/Palliative Care Rotation

Patient Population

The patient population of the hospice program spans a wide range of diagnostic categories, level of functioning, and severity of illness. The age range of Veterans on the hospice unit is generally between early 50's to late 80's. Many of the Veterans admitted suffer from chronic liver disease, cardiovascular disease and/or some form of cancer, generally lung or pancreatic with metastases. The older Veterans may also have an underlying form of dementia or related cognitive disorder. Interns working on the hospice rotation will work with a wide range of mental health disorders, including a history of Substance Use Disorder, Depression, Anxiety, and Post Traumatic Stress Disorder. Also, interns will have the opportunity to work with patients' families and staff members to deliver interventions for caregiver support and burnout.

Assessments, Treatment and Supervision

This major rotation is designed to provide interns the opportunity to work predominantly with patients on a 12 bed inpatient hospice unit and to interact collaboratively with an interdisciplinary team. Interns will evaluate patients upon admission to the hospice unit for underlying psychopathology (i.e. depression, anxiety, adjustment disorders, suicidal ideation vs. desire for dying process to be over, PTSD, personality disorders, chronic mental illness, underlying delirium). From those evaluations, a caseload will be assigned for the intern to follow. Depending on the schedule, interns will also be expected to attend weekly hospice rounds and interdisciplinary team/family meetings. The interns will have weekly supervision and will develop knowledge and skills for working with normative and non-normative grief and bereavement. In addition, assessment of specific psychosocial and mental health issues common in patients with chronic, life limiting or terminal illness and their families will also be addressed. Interns will also develop the ability to modify practice to accommodate end of life context with regard to self-disclosure, boundaries, structure, ability to communicate effectively with medical and non-medical professionals without psychological jargon, etc. The turnover rate on the hospice unit can be rather fast with patients staying on the unit anywhere from months to days. If necessary, caseload can be expanded with residents in the rehabilitation or nursing home units. In addition to initial evaluations, interns will have the opportunity to conduct evaluations associated with decisional capacity and factors contributing to/complicating decisions.

In addition, the intern will be responsible for leading a weekly caregiver support group which is offered to family members of current and past patients of the hospice unit as well as other family members of the CLC patients who have been diagnosed with a terminal illness. The intern will also have the opportunity to participate in a monthly support group offered to hospice staff members.

Supporting Literature

Journal of Palliative Medicine, Psychooncology, Journal of Pain and Symptom Management
APA online end-of-life training modules
Stanford End-of-Life Care curriculum (<http://www.growthhouse.org/stanford/modules.html>)
National Cancer Institute Education in Palliative and End-of-Life Care for Oncology (EPEC-O)
End of Life/Palliative Education Resource Center (EPERC)
End of Life Nursing Education Consortium (ELNEC)
Duke Institute on Care at the End of Life (<http://www.iceol.duke.edu/>)
Fast Article Critical Summaries for Clinicians in Palliative Care (PC-FACS)

Supervisor's Training and Experience

Steven Butz, Psy.D. is the Clinical Geropsychologist and Neuropsychologist for the Loch Raven Community Living and Rehabilitation Center. He obtained his doctorate degree in clinical psychology from Loyola University of Maryland where he is also an affiliate faculty member. He completed a post-doctoral fellowship in geropsychology through the VA Boston Healthcare System/Harvard Medical School. His clinical work has been conducted in both outpatient and inpatient settings with responsibilities that have included neuropsychological testing, decisional capacity evaluations, psychotherapy, and behavioral management for residents in a variety of outpatient and inpatient settings, including independent living, assisted living, nursing home, rehabilitation and hospice units.

University of Maryland School of Medicine -University of Maryland Medical Center Internship Positions: Adult and Child

University of Maryland Adult-Focused Internship Positions

Overview

There are two University of Maryland (UM) Adult-Focused Positions:

UM Serious Mental Illness Track (UM SMI)

UM Adult Outpatient Integrated Health Track (UM Integrated Health)

Interns in these positions participate in a year-long placement at one of two UM mental health treatment programs, both of which are located in the Walter P. Carter Center Building at 701 West Pratt Street, Baltimore. These two positions are distinct and represent separate, individual tracks available in the consortium. This brochure presents information that applies to both positions first, followed by track-specific information. Interns in both positions are employees of University of Maryland Medical Center and work in their respective programs for the entire training year as their primary placement (i.e., a minimum of 24 hrs./week). In addition to working in their primary program, interns can choose from a variety of minors to attend 4-6 hours/week and will have time dedicated to research and assessment.

Both programs have long histories of serving public sector and other patients from the surrounding communities in Baltimore city and its metropolitan area. They serve individuals aged 18 and older and offer diagnosis and treatment of mental health and substance use disorders that are often comorbid with physical health, trauma, social, family, relationship, and legal issues. These programs are staffed by multidisciplinary teams that include social workers, psychologists, nurses, medical residents, and physicians. Both programs view recovery as a process and offer services that emphasize collaboration, hope, respect, and empowerment. These programs emphasize the use of evidence-based practices and client collaboration in the treatment process through shared decision making. Both programs offer trauma-informed care that closely attends to the impact of trauma on daily functioning and symptom presentation.

The population served at both programs is diverse with regard to diagnosis and illness severity. Their location in downtown Baltimore means that these programs serve an urban population that experiences significant barriers to mental health care and recovery. Both programs serve adults age 18 and over who present with a broad range of emotional and behavioral problems, including mood disorders, anxiety disorders, trauma-related disorders, including post-traumatic stress disorder, schizophrenia and other psychotic disorders, personality disorders and co-occurring psychiatric, medical, and substance use

disorders. These programs provide intake and diagnostic evaluation, individual and group therapy, medication evaluation and management, and case management services or referrals. In addition, both programs adhere to a multidisciplinary team model that includes psychiatrists, psychiatry residents, social workers, psychologists, and nurses along with the psychology intern. Importantly, both programs work to incorporate empirically validated interventions as part of clinical service and function within a mental health service delivery system that is adapting to the demands of an ever-changing mental health care environment.

Interns in these positions serve as integral members of the each program's multidisciplinary team and function with increased independence as the year progresses. Interns gain supervised experience providing a range of services including intake and diagnostic evaluation, individual and group psychotherapy including cognitive-behavioral and other interventions, and psychological assessment. Interns co-lead behaviorally-oriented treatment groups on topics related to coping and symptom management, trauma, cognitive behavioral therapy, dual disorders, social skills training, and health behavior change topics such as smoking cessation and medical illness management. Interns may have the opportunity to develop group treatments in which they hold interest or expertise. Opportunities also exist for co-leading groups related to coping with grief and loss, empowerment, recovery, and acknowledging and healing self-stigma. As part of the treatment team, interns attend team meetings and present at case conferences. Interns are also involved in aspects of case management and care coordination for their clients in order to support their trust in treatment seeking, engagement, and success in mental health treatment. It is highly valued that interns are well-supported in managing their resilience and improving their professional development while working with a challenging population. Additional administrative supervision is provided to ensure that interns function in accordance with clinic procedures. Overall, the opportunity to complete a year-long placement allows the intern to function as the face of psychology within the treatment team, develop relationships with other clinicians on that team, and provide services within the context of a community mental health treatment program for an extended period of time.

Consistent with the overall Consortium assessment requirements, interns are supervised in the completion of six assessment batteries and corresponding reports. Referrals often come from members of the treatment team and involve in-depth diagnostic assessment of complex cases, personality assessment, and cognitive and intellectual functioning. Interns provide feedback and education regarding recommendations to clients and other clinicians on the treatment team. Assessments may also occur within the context of VA clinics or as part of a minor rotation.

UM Serious Mental Illness (UM SMI) Track

Please note, the UM SMI Track position WILL NOT be offered for the 2019-2020 training year. This rotation will resume in 2020-2021 and specific track information will be provided at that time.

UM Adult Outpatient Integrated Health (UM Integrated Health) Track - Outpatient Psychiatry Clinic

The UM Integrated Health Track provides comprehensive assessment, psychiatric diagnostic evaluation, and interventions for people experiencing mental health disorders. Some clients come from the local community while others are referred from medical services with the University of Maryland Medical Center. Clients are primarily seeking treatment for affective and anxiety disorders. Most have experienced childhood and/or adult trauma that influences their symptoms and response to treatment.

Comorbid substance use disorders and somatic health problems are common. A typical caseload usually has 20-25 clients. The psychology intern works alongside the other care providers on the team: a psychologist, social workers, third-year psychiatry residents, and staff psychiatrists. The intern is a full member of the treatment team and is expected to actively participate in all aspects of that team, including planning and collaborating on client care and contributing to clinic operations. One way in which the intern does this is by serving as the “chief” for a 3-month period, the primary task of which is communicating with the treatment team about and organizing intake assignments. The intern provides individual and, when available, group treatment, and conducts intake and psychological assessments, providing a psychological perspective of the development of psychopathology, of recovery and trauma-informed treatment, and of treatment plan development and implementation. Treatment modalities include individual psychotherapy, group therapy, and medication management. Clinicians utilize and can provide supervision in the implementation and integration of various treatment modalities including motivational interviewing/enhancement, CBT, DBT, interpersonal, supportive, and other empirically-supported interventions.

In addition to the year-long clinic placement and individual client caseload, interns select 2-3 clinical placements or “minor” rotations within the University of Maryland Medical Center and the Baltimore VA Medical Center. These can include:

Motivational Interviewing for Substance Use Disorders. The intern will have the opportunity to participate in the Motivational Enhancement Therapy (MET) Minor Rotation, based at the VA and led by Drs. Jade Wolfman-Charles and Kara Biondo. Interns will receive MET training from VA National Consultants and will go on to complete individual assessment and feedback therapy sessions with Veterans, using a structured protocol, as well as a weekly MET time-limited psychotherapy group. Training activities include: (1) Full day Motivational Interviewing (MI) training led by VA National Consultants (typically held in September); (2) 90-minute 12-week interdisciplinary MI Consultation group for trainees facilitated by VA National Consultants, (3) Weekly MET psychotherapy group, (4) Up to 2 individual 50-minute assessment and feedback sessions per week, and (5) 1 hour of group supervision.

University of Maryland Medical Center Department of Medicine, Division of Pulmonary and Critical Care, Sleep Disorders Center (Midtown Campus). This rotation will provide experience in hospital-based sleep disorders assessment and treatment under the direction of Dr. Emerson Wickwire, head of the Insomnia Program at UMMC. The intern will complete introductory sleep-related readings, shadow in the sleep clinic, learn about treatment planning for insomnia and other sleep disorders, and interact with an integrated medical team.

University of Maryland Medical Center Greenebaum Cancer Center. A minor at this location offers the intern the opportunity to meet with patients diagnosed with cancer. Activities include meeting with patients while they are receiving transfusions and educating them about maintaining good mental health while experiencing major medical concerns, as well as to screen for psychological symptoms that may be pre-existing or resulting from their diagnosis. The intern can provide patients with brief interventions and information about resources and the benefits of seeking more intensive psychological support as they cope with their health concerns. In addition, the intern co-leads an oncology support group with a psychiatry resident. If patients with whom interns interact have Maryland’s Medical Assistance for insurance, interns may refer these patients to the UM Adult Outpatient Psychiatry Clinic and see them on a regular basis.

University of Maryland Medical Center Department of Family and Community Medicine. The Department of Family & Community Medicine offers comprehensive primary care to patients of all ages, including obstetric, pediatric and geriatric patients. In this rotation, the intern would work with a staff member at the Family Medicine office to gain experience implementing brief behavioral medicine/health psychology interventions and using Cognitive Behavioral Therapy (CBT) to address issues related to physical and mental health in the hospital setting. If patients with whom interns interact have Maryland's Medical Assistance for insurance, interns may refer these patients to the UM Adult Outpatient Psychiatry Clinic and see them on a regular basis.

University of Maryland Medical Center Geriatric Psychiatry Outpatient Clinic. Issues of aging commonly co-occur with mental health disorders in older clients. This rotation will give the intern an opportunity to provide mental health services to older clients with mental health disorders and to gain experience in assessment, treatment planning, and intervention with older clients in a community outpatient setting. Possible experiences include group of individual case work overseen by the staff of this clinic who have expertise in working with older adults.

Cognitive Behavioral Treatment for Insomnia (CBT-I) Training. Individuals with mental health disorders have high rates of insomnia that can complicate mental health symptoms and response to treatment. This rotation would offer the intern the opportunity to work with VA Psychologist Dr. Beth Klingaman to receive training in CBT-I and treat at least one case using CBT-I under Dr. Klingaman's supervision.

Supervisor Training and Experience

Miranda Kofeldt, Ph.D. earned her doctorate from the University of Maryland Baltimore County. Dr. Kofeldt worked for one year at the University of Maryland College Park as a Research Assistant Professor and Assistant Director of Clinical Training. She currently conducts individual (and as available, group) psychotherapy as a psychologist at the University of Maryland Medical Center Adult Outpatient Psychiatry Clinic (2nd floor of 701 W. Pratt St), where she also completed her internship. She provides clinical, administrative, and assessment supervision of the intern in this clinic. Her clinical approach and interests focus on the Transtheoretical Model of Behavior Change, motivational interviewing and motivational enhancement techniques, trauma-informed approaches to treatment, and cognitive behavioral therapies.

Patricia Widra, M.D. received her M.D. from Rutgers University School of Medicine in NJ and completed her training in Psychiatry at Jefferson Hospital in Philadelphia. Dr. Widra has worked in Reproductive Psychiatry since 1998 when she developed the postpartum depression screening program for the OB/GYN Department at Georgetown Medical Center. In her private practice, prior to rejoining the faculty at University of Maryland, she continued to work with women in managing psychiatric disorders before and during pregnancy. She returned to University of Maryland last October to develop a Women's Mental Health Program, which now includes integration of screening and evaluation of PMADs at four sites. She is a member of Postpartum Support International, Perinatal Mental Health Society and the Baltimore Perinatal Mental Health Professional Study Group. In addition to treating women in the perinatal period, she provides psychiatric consultation to patients treated in the University of Maryland Marlene and Stewart Greenbaum Comprehensive Cancer Center and participates in their multidisciplinary supportive services program.

Jade Wolfman-Charles, Ph.D., a VAMHCS Supervisory Staff Psychologist and the Psychology Training Program Director, completed her degree in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Charles has specialized training in evidence based practices including Cognitive Behavioral Therapy, Motivational Interviewing/Motivational Enhancement Therapy, Acceptance and Commitment Therapy and Cognitive Processing Therapy and serves as a Consultant and Regional Trainer for the VA National Motivational Interviewing Initiative.

University of Maryland Child-Focused Internship Positions

There are 4 University of Maryland (UM) Child-Focused Internship Positions across two tracks:

UM Clinical High Risk for Psychosis Track
UM School Mental Health Track

Please note, the UM SMI and Child Outpatient Track positions WILL NOT be offered for the 2019-2020 training year. These rotations will resume in 2020-2021 and specific track information will be provided at that time.

University of Maryland Clinical High Risk for Psychosis (UM CHiRP) Track.

The UM CHiRP Track is housed within the Department of Psychiatry, Division of Child and Adolescent Psychiatry in the UM School of Medicine. The CHiRP program is a SAMHSA funded research clinic for youth at clinical high-risk for psychosis, recently developed in collaboration with University of Maryland Baltimore County (UMBC), University of Maryland Baltimore (UMB), and the Maryland Early Intervention Program (MEIP). The CHiRP intern in this position completes a primary year-long clinical placement within the Division of Child and Adolescent Psychiatry. The CHiRP intern will gain supervised training and experience conducting intake and diagnostic evaluations, individual and group cognitive-behavioral therapy for clinical high-risk (CHR), provision of consultation with care providers, supervision of doctoral externs, community outreach and education, program development, and research opportunities. Some travel from the University of Maryland Baltimore to the University of Maryland Baltimore County and to the Spring Grove Campus in Catonsville, MD will be required as part of the track (all within 20 minutes of UMB).

The UM CHiRP Track provides advanced training in clinical practice, research, training, and policy related to youth at clinical-risk for psychosis.

Clinical – Interns will be involved in all aspects of clinical services, providing a range of intervention services including: provider consultation, psychoeducation for individuals and family members, CBT and skills training, supported education and employment, safety planning and emergency service use reduction, and substance abuse treatment and risk reduction. Interns will complete a clinical rotation (3 days per week) at the CHiRP clinic housed within the UM SOM Division of Child and Adolescent Psychiatry, where they will be trained in the provision of modularized CBT for youth at clinical high-risk for psychosis. Clients include youth ages 12-25 and their families from the diverse, often underserved population in the greater Baltimore area, as well as individuals throughout the state of Maryland (including rural, underserved areas)

that are seen through the telehealth program. Interns will also have the opportunity to conduct structured intake interviews, assist with program evaluation and development, and provide outreach and psychoeducational programming for providers and community members in the greater Baltimore area. The intern's caseload will include individual and group psychotherapy, assessment, provider consultation, and supervision, with the expectation of accruing 15 - 20 intervention hours per week. The intern will receive supervision two hours per week with a licensed psychologist and additional supervision with other mental health care providers to review cases, provide further intervention training, and establish concrete treatment plans. **Assessment.** The CHiRP intern will provide a minimum of 6 comprehensive assessments to the CHiRP clinic or other UM clinics for treating early psychosis (approximately 6 hours per week). **Didactics** The CHiRP Track promotes interprofessional collaboration and culturally competent, evidence-based practice. The CHiRP intern will receive the following didactic components: (1) a weekly, cross Consortium seminar (2.5 hours); (2) specialized intensive trainings (at training events, at conferences, and as part of the rotations) from Dr. Schiffman, a leading expert on CHR assessment and treatment, twice yearly.

Research – Primary research topic areas for the CHiRP intern to pursue as part of the research requirement for the internship and as part of the larger CHiRP internship experience would fall under three main categories described below:

Maryland Early Intervention Program

A large proportion of YouthFIRST's overall efforts are dedicated to supporting the Maryland Early Intervention Program (EIP). The EIP is a state-wide consortium designed to improve the lives of young people in the early stages of psychosis. Funded in part by the state of Maryland, the EIP is operated by multiple centers and departments within the University of Maryland Medical Center (including the Maryland Psychiatric Research Center (MPRC), Child and Adolescent Psychiatry, Adult Psychiatry), and the University of Maryland, Baltimore County. Dr. Schiffman is a co-founder and steering committee member of the EIP.

Multiple core initiatives are central to the EIP: (1) *Research* concerning the identification, treatment, phenomenology, and etiology of psychosis; (2) *Outreach and Education* services to behavioral health providers, schools, and primary care settings; (3) *Clinical Services* for 12-30 year-olds who have recently experienced an initial episode of psychosis, or are suspected of being at risk of future psychosis; (4) *Consultation Services* for providers regarding identification and treatment of individuals who may be experiencing early symptoms of psychosis; (5) *Training and Implementation Support Services* to foster collaboration, resource sharing, and coordination of service delivery among established early intervention teams across the state of Maryland. More information about the EIP can be found at <http://www.marylandeip.com>.

Strive for Wellness Clinic

Members of YouthFIRST constitute core members of each EIP initiative, several of which are achieved in part by the EIP's Strive for Wellness (SFW) clinic. Co-directed by Youth FIRST director Dr. Schiffman, SFW is an early identification, research, and services clinic specializing in youth ages 12-25 who are suspected of being at clinical high-risk (CHR) for the onset of a psychotic disorder. Participants in SFW research complete an extensive assessment battery and are reevaluated every 6-12 months for several years. Although the SFW clinic is especially concerned with the CHR

population, all individuals ages 12-25 who are receiving mental health resources are potentially eligible for research participation. This novel research paradigm provides unique clinical and research opportunities for trainees at YouthFIRST.

Within this longitudinal clinical research context, the SFW team is able to investigate an array of empirical questions. Current projects taking place within the EIP's SFW clinic include the following:

- Evaluation and development of brief screening tools to identify those most likely to meet high-risk criteria and develop psychosis
- Multimodal neuroimaging to identify neural biomarkers of psychosis risk
- Assessment of family functioning, stigma toward mental illness, and quality of life
- Experimental assessment of reward learning, aberrant salience, and neurocognitive functioning
- Examination of metabolic and other physical health parameters through blood assay and ecological momentary assessment

Multisite Assessment of Psychosis Study (R01)

The entry criteria for studies of CHR syndromes have traditionally required that participants be seeking mental health care at the time of assessment. This criterion has functioned as a proxy for distress or psychosocial impairment, with the intention of zeroing in on a group of people who may be truly at risk for a serious illness like schizophrenia. As a result, however, the knowledge of CHR to date is restricted to those with significant and developed psychiatric histories. The extent to which CHR syndromes in the general (potentially non-help-seeking) population reflect those represented in most CHR research remains unknown.

In the first study of its kind, the YouthFIRST team and its collaborators are developing a novel screening instrument to detect psychosis-risk in the general population. Several thousand adolescents and young adults in three major cities (Baltimore, Philadelphia, and Chicago) will be recruited from the community and surveyed for known psychosocial and environmental risk factors for psychosis, including attenuated psychotic symptoms, sleep disturbances, and levels of stress exposure, among others. High-scoring participants and a random sample of low-scoring participants are subsequently invited into the laboratory for an in-depth, gold-standard clinical assessment of CHR and other psychiatric syndromes. The combined results of these two study phases will be used to empirically develop a brief self-report instrument with high ability to assess the likelihood of meeting CHR criteria and an unfavorable course of functioning. Led by YouthFIRST at UMBC and colleagues at Northwestern University and Temple University, this epidemiological study was recently funded by a large (R01) grant from the National Institute of Mental Health.

Social Work Training to Reduce the Duration of Untreated Psychosis (R34)

The longer the interval between the clinical onset of psychosis and first exposure to treatment, referred to as the duration of untreated psychosis (DUP), the worse the course of illness and functioning. Conversely, the quicker initial psychosis is treated, the more favorable the outcome. Given that DUP is one of the few known modifiable risk factors for the course of illness, research and clinical efforts to reduce the average DUP are critical. In the United States, however, DUP remains too long. Prior efforts

to reduce DUP have been met with only modest results, possibly because outreach efforts have targeted the wrong stakeholder groups. Social workers constitute the majority of the human services and mental health workforce and represent a segment of the workforce likely to have direct contact with people in the early phases of psychosis. Social workers therefore may be an ideal group to engage toward the goal of reducing DUP.

Recently funded by the National Institute of Mental Health (R34), this randomized controlled trial will administer an innovative online training program to over 1,200 clinical social workers in the state of Maryland. The training is designed to increase awareness of early psychosis and knowledge of screening implementation. Participating social workers are educated on the Maryland EIP, an early psychosis specialty network directed in part by Dr. Schiffman. The training is expected to facilitate rapid access to specialty care for those suspected of experiencing CHR or early psychosis, circumventing the extended DUP that is characteristic of current treatment as usual. This study represents a partnership between YouthFIRST, the Maryland EIP, and the University of Maryland School of Social Work.

Maryland Clinical High Risk for Psychosis (CHiRP) Grant (SAMHSA)

This project intends to fundamentally improve the lives and functional trajectories of adolescents and young adults at clinical high-risk (CHR) for mental illness with psychosis. We are expanding our already existing CHR collaboration between the University of Maryland School of Medicine (UMSOM), UMBC, and the Maryland Behavioral Health Administration to create a comprehensive, evidence-based, stepped model of care clinic. Drawing from the available literature on treatment for those at CHR, we have distilled treatment components from demonstrably effective CHR clinical trials into a series of modules that are matched to the client's idiographic and staged needs. Central components of the stepped intervention include culturally-sensitive and state-of-the-art assessment, psychoeducation, cognitive behavioral therapy (CBT) for CHR as well as other concerns, supported education and employment, substance use treatment, and pharmacotherapy, as well as seamless transfer to specialty care within our existing clinical network in the case of an emergent disorder with psychosis.

Through a consumer and culturally-informed approach, our clinical goals are to, 1) improve social and role functioning and quality of life among clients; 2) reduce the severity of psychosis-risk symptoms as well as other concerns (e.g. mood, substance misuse); 3) prevent or delay progression to formal psychosis; and 4) curb the burden of the first episode of psychosis (FEP) through stepped care, if diagnosable psychosis is to emerge. Our research goal is to investigate the effectiveness of these efforts.

Policy: The CHiRP intern would have the opportunity to learn more about state policy and regulations related to early identification and support of youth experiencing first episodes of psychosis as part of participation in Maryland EIP meeting, issues relating to sustainability for CHiRP services, and other state meetings and opportunities.

Training

The CHiRP intern would have the opportunity to help supervise a Master's Level extern and would also as part of the Maryland EIP Outreach team provide outreach and education to stakeholders (e.g., primary care providers, educators, health and mental health staff, hospital staff, emergency room staff, policymakers) on the basics of the early identification and treatment of youth with psychosis.

Support from the Literature

People at CHR often struggle with an array of mental and behavioral health challenges (e.g. attenuated psychosis symptoms, depression, anxiety, impaired social and role functioning, trauma). Youth in our catchment area are often exposed to environmental risk factors for psychosis (e.g. poverty, violence, substance use)^{1,2,3}, increasing their risk for CHR symptoms and poor outcomes more broadly, and need for specialty services^{4,5,6,7,8,9}. Our catchment area is affected by prominent substance-use problems¹⁰, as well as high rates of comorbid mental health concerns (e.g. depression, anxiety)¹¹. Despite the elevated need and risk, affected youth usually go undetected and untreated^{12,13}. A growing body of evidence suggests that early intervention can delay, mitigate, or in some cases prevent future psychosis^{14,15}. The MD Early Intervention Program (MD EIP) CHR Clinic represents the sole specialty services provider in MD designed for youth at CHR. We regularly receive referrals for care from our MD EIP central line, as well as directly from the community. Our team's consumer-oriented approach, track-record of community outreach and engagement, telehealth infrastructure, and crisis management experience make us ideally equipped to offer services to reach individuals at CHR, many of whom represent underserved populations. The large number of youth at CHR we have identified through outreach and assessment in our work suggests a compelling need for our CHR services. *Needed innovations for youth at CHR include additional and accessible CHR-specific clinical services designed for a diverse range of people (many having barriers to care). Clinical interns will be an important contributor to this mission.*

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Affiliated Programs

The following centers/programs are affiliated with the CHiRP internship

Center for School Mental Health (CSMH): The CSMH is co-directed by Drs. Nancy Lever and Sharon Hoover. The CSMH is the only federally-funded (HRSA) SMH program, research, and policy analysis center. Its mission is to *strengthen policies and programs in ESMH to improve learning and promote success for America's youth*. The CSMH is co-leading, with the School-Based Health Alliance, the School Health Services National Quality Initiative (NQI). The NQI strives to advance accountability, excellence and sustainability for school health services nationwide by establishing and implementing an online census and national performance measures for school-based health centers and comprehensive school mental health systems. As part of these efforts the Center has developed the School Health Assessment and Performance Evaluation (SHAPE) System to help improve the quality and sustainability of school mental health systems in the United States. The Center works at local, state, and national levels to advanced research, training, policy, and practice in SMH. Interns are involved in and lead numerous projects, such as advancing the literature and best practices needed to address trauma, documenting the quality and effectiveness of SMH services, increasing family engagement in mental health services delivered in schools, and advancing the SMH workforce by developing curriculum and training materials. Other opportunities for interns include grant writing (e.g., for federally funded projects, private foundations, and state and local projects), writing book chapters and peer-reviewed journal articles, preparing content for the listserv, and critically reviewing articles for leading SMH journals. Additionally, interns have the opportunity to contribute to the ongoing mission of the CSMH through helping to develop practical resources for educators, youth, families, and mental health providers, as well as authoring issue briefs and articles geared toward enhancing the dissemination of best practice and research in SMH.

School Mental Health Program: The School Mental Health Program is led by Dr. Nancy Lever, Executive Director, Jennifer Cox, LCSW-C, Program Director, Kelly Willis, LCSW-C, Associate Director, Dr. Sharon Hoover, Senior Advisor, and Dr. Brittany Patterson, Faculty Advisor. The SMHP is a longstanding (established in 1989), interdisciplinary outpatient mental health program that provides high quality comprehensive school mental health services (promotion, prevention, intervention, consultation) to youth and families in 25 Baltimore City schools working in close collaboration with families, schools, and communities. The SMHP has achieved national recognition for its commitment to advance access to high quality mental health care in schools. Baltimore was among the first nationally to develop school-based health centers, and has become a leader in the systematic development of comprehensive school mental health programs. The SMHP staff is comprised of licensed social workers, professional counselors, psychologists, and graduate trainees (social work, psychology,

counseling, psychiatry, nursing). The SMHP is one of four lead programs in Baltimore City providing SMH services. SMH services augment the work of school-employed mental health providers, are available to youth in both general and special education, offer a full continuum of mental health services within the school, and are intended to reduce barriers to learning and promote student success. The SMHP is committed to implementing evidence-supported practices and programs across the Public Health Triangle. With many faculty within the SMHP having expertise in several evidence-based practices and programs (e.g., Modularized Practice/Common Elements, Coping Power, CBITS, FRIENDS), there are numerous opportunities for specialized training and skill practice.

Maryland Psychiatric Research Center: Under the leadership of Dr. Bob Buchanan, The Maryland Psychiatric Research Center (MPRC) is an internationally renowned research center, which is dedicated to providing treatment to patients with schizophrenia and related disorders, educating professionals and consumers about schizophrenia, and conducting basic and translational research into the manifestations, causes, and treatment of schizophrenia. The MPRC is a University of Maryland School of Medicine (UMSOM) Organized Research Center, which resides in UMSOM Department of Psychiatry and operates as a joint program between UMSOM and the Maryland Department of Health.

Youth Focused Identification, Research, and Service Team (YouthFirst): YouthFIRST is a research team in the Department of Psychology at the University of Maryland, Baltimore County. Directed by Professor Jason Schiffman, Ph.D., the lab is dedicated to producing meaningful and useful research in the context of providing clinical services, while at the same time training future leaders in psychology. We focus on the scientific understanding of the origins of, and treatment and assessment for, schizophrenia-spectrum (“spectrum”) and psychotic disorders in youth and young adults. We define our research into three overlapping themes including: (1) genetic high-risk research, (2) clinical high-risk research, (3) clinical services research.

Maryland Early Intervention Program: The Maryland Early Intervention Program (MEIP) is a collaborative effort among several centers, including the University of Maryland School of Medicine Department of Psychiatry’s Maryland Psychiatric Research Center, Center for School Mental Health, Psychology, and Psychiatric Services Research; the University of Maryland Medical System’s Divisions of Child and Adolescent Psychiatry and Community Psychiatry; and the University of Maryland-Baltimore County Department of Psychology. This program was established in part by funding from Maryland's Department of Health. The MEIP offers specialized programs with expertise in the early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early stages of, a mental illness with psychosis. It uses an integrated approach to addressing the health and mental health needs of young adults, including providing support for co-occurring substance use disorders, metabolic risks, and other co-occurring medical conditions. The MEIP is committed to reducing disability by equipping individuals and their families with tools to manage their illness, move successfully through the developmental stages of growth, and establish a life of their choosing. The MEIP includes four components: 1) Outreach and Education Services to groups interested in learning more about the early stages of mental illnesses with psychosis; 2) Clinical Services to individuals experiencing early psychosis and their families; 3) Consultation Services to professionals working with individuals experiencing early psychosis and their families; 4. Training and Implementation Support to professionals establishing Early Intervention Teams

UM CHiRP Track: Supervisors’ Training and Experience

Kristin Bussell, RN, NP is a psychiatric and mental health nurse practitioner at the University of Maryland Medical Center. As a nurse practitioner, Ms. Bussell’s assists patients and families in making healthy lifestyle choices and behavioral changes that lead to improved health outcomes. She also works

with those at clinical high risk for psychosis population to improve both metabolic (obesity-related) and mental health outcomes for young people. She currently serves on the interdisciplinary CHR clinical team at University of Maryland, and has completed training on tools used to evaluate CHR symptoms, including the Structured Interview for Prodromal Syndromes (SIPS). She coordinate telepsychiatry consultations to a rural, underserved community and also implements CHR evaluation study protocols. She has a longstanding history of collaboration with the clinical treatment team, and is committed to providing clinical support needed for implementation of CHR services and outreach to the community. *Kay Connors, L.C.S.W.*, is the Co-Director of the Center of Excellence for Infant and Early Childhood Mental Health and the project director for the Family Informed Trauma Treatment Center, and has over 30 years of experience working with traumatized children and their families. Ms. Connors has provided mental health treatment to children and families in a variety of settings, including hospital, residential treatment, private practice, clinic, and home-based programs. Ms. Connors has directed programs, supervised staff, participated in outcome research as well as trained trainees and audiences locally and nationally in infant and early childhood and trauma treatments.

Sharon Hoover, Ph.D., received her Ph.D. in clinical psychology from the University of Maryland Baltimore County in 2002, completing her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine at the Center for School Mental Health (CSMH) and the School Mental Health Program. She is the Co-Director of the CSMH and an Associate Professor in the Department of Psychiatry. Dr. Stephan's clinical and research focus is in the implementation of empirically-supported interventions in schools, with a particular emphasis on serving traumatized youth and youth from health-disparate populations. She conducts research and clinical training in the areas of mental health-primary care collaboration and integration, quality assessment and improvement, co-occurring disorders, school transitions, and trauma. She provides research and clinical supervision within the SMH track.

Nancy Lever, Ph.D., is the Co-Director of the Center for School Mental Health, Director of the University of Maryland School Mental Health Program, and an Associate Director of the VAMHCS/UM SOM Psychology Internship Consortium. She completed her undergraduate degree in psychology at Dartmouth College and her doctoral training in clinical psychology at Temple University. She completed her child internship and SMH postdoctoral training at the University of Maryland School of Medicine before joining the Department of Psychiatry in 1998. She is an Associate Professor in the Division of Child and Adolescent Psychiatry. She has been very active in promoting training related to SMH and has coordinated training experiences for psychology interns, psychiatry fellows, and postdoctoral fellows. She has presented and written extensively about school mental health and leads local, state, and national efforts related to advancing school mental health quality and sustainability. Research interests include: quality assessment and improvement, dropout prevention, workforce development, promoting resiliency, substance use prevention, and trauma-informed care. She oversees the SMH track and provides clinical and research supervision and training.

Jason Schiffman, Ph.D., is a Professor with appointments at both UMBC and UMB. He is Director of Clinical Training, Director of the YouthFIRST lab in the Department of Psychology at UMBC. He completed his Ph.D in 2003 at the University of Southern California under mentorship of Sarnoff Mednick. He received his undergraduate degree in psychology at Emory University under mentorship of Elaine Walker. Dr. Schiffman's research interests include early identification and treatment of youth at risk for psychosis and the reduction of stigma against people with serious mental health concerns.

Gloria Reeves, MD, is a child and adolescent psychiatrist with specialized expertise in pediatric psychopharmacology and obesity-related health issues among individuals with serious mental illness. Dr. Reeves received her medical degree from the University of Maryland School of Medicine and completed a NIH-funded career development award to develop skills in state-of-the-art metabolic assessments of youth and adults with mental illness, and she has collaborated with interdisciplinary experts to study obesity-related side effects of antipsychotic medication treatment. Dr. Reeves partnered

with pharmacists, child mental health experts, and child-serving state agency leadership to help develop an antipsychotic medication prior authorization program for publically-insured youth. Dr. Reeves is the Medical Director of the Strive for Wellness program, a hybrid clinical and research program focused on psychosis prevention.

UM School of Medicine School Mental Health (SMH) Track

The UM School of Medicine and its Center for School Mental Health (CSMH) in Baltimore, Maryland is nationally recognized as a leading inter-professional training program in school mental health (SMH) for psychology, social work, counseling, and psychiatry trainees. UM SOM is the only American Psychological Association (APA) Accredited psychology internship that offers comprehensive major rotation experiences in SMH practice, research, and policy with a goal of preparing scientist-practitioners to work in schools directly with vulnerable and underserved populations. A key mission of the SMH track is to increase the number of psychology interns who pursue careers in research, clinical practice, education or policy that help to serve and meet the needs of underserved and vulnerable populations. The School Mental Health Internship Track was awarded APA's Award for Distinguished Contributions for the Education and Training of Child and Adolescent Mental Health Psychologists.

The UM School of Medicine SMH Track provides advanced training in SMH practice, research, and policy and is designed to train psychologists in skills to improve access to high quality SMH services and programming (e.g. system-wide prevention efforts, focus on public health concerns), while reducing mental health care disparities. Specifically, SMH Track interns provide a full continuum of mental health services (i.e., mental health promotion, prevention and intervention) to youth and families directly in the community through a school placement. Interns provide this full array of mental health services at their major SMH placement in the UM SOM School Mental Health Program (SMHP) in Baltimore City, Maryland. In terms of the major SMH rotation, interns provide clinical services to one school in a low-income and highly-stressed urban community predominantly serving minority youth and families in which a large percentage of students served have experienced significant trauma. Overall, SMH interns, working with school teams, provide evidence-based intervention, prevention, consultation, assessment, and mental health promotion services to youth across the developmental span with mental health and/or substance abuse disorders.

The comprehensive SMH Track provides a unique opportunity for interns to receive an intensive experience in comprehensive school mental health (SMH) across three critical realms: clinical practice, research, and policy. Additional aspects of the program include didactic, research, and policy training in evidence-based practices and a focus on advancing quality and sustainability in school mental health efforts. Training and supervision are provided by 1) the Center for School Mental Health and 2) The Family Informed Trauma Treatment Center.

Clinical. Interns receive rigorous clinical training across a three-tiered public health framework with major rotations within 1) the UM SMH Program (SMHP) in Baltimore City Public Schools and 2) the Maryland Psychological Assessment and Consultation Clinic (MPACC). Interns will complete an intensive clinical rotation (3 days per week) within a school setting in which they provide a full continuum of evidence-based mental health services to underserved, diverse youth (ages 5-19 years) across a three-tiered public health framework (universal, targeted and selected interventions) in one of the 27 Baltimore City Public Schools (elementary, middle, or high school). Interns provide evidence-based individual, group, and family therapies; prevention and mental health promotion activities for small groups, classrooms, and school-wide programs; consultation to teachers, staff, and administrators; crisis intervention; and referral to community resources. Additionally, interns conduct assessments at the MPACC throughout the year (6 hours per week).

All SMH interns are responsible for coordinating and responding to referrals for mental health services as well as providing the direct services described above. There are also opportunities for participation on school teams and to be involved in the implementation of school-wide mental health promotion and prevention programs to improve the school and early childhood center climate (e.g., violence prevention programs, mentoring, positive behavioral interventions and supports). Primary therapeutic modalities include cognitive behavioral and family systems approaches. These are combined with psychopharmacological intervention from UMB Psychiatry Fellows when indicated. Family involvement is emphasized for both diagnostic and therapeutic services. In addition, collaborative working relationships are developed with school and early childhood staff, community agencies and programs, advocacy organizations, and other university programs. The patient caseload will include individual and group psychotherapy clients, with an expectation that at least eight students are seen per day. The intern will receive supervision two hours per week with licensed psychologists to review cases, provide further intervention training, and establish concrete treatment plans. Additional supervision and support will be provided by other SMHP leadership representing social work, counseling, and psychiatry fields.

Didactics. The SMH Track promotes interprofessional collaboration and culturally and linguistically competent, evidence-based practice; this curriculum is integrated throughout the internship didactic training. The curriculum is presented throughout the following didactic components: (1) a weekly, cross Consortium seminar (2.5 hours); (2) a weekly interprofessional SMH seminar series (60 minutes each); (3) a monthly interprofessional case conference with psychiatry fellows and SMH psychology and social work professionals (1 hour); and (4) specialized intensive trainings (during the summer months, at training events, at conferences, and as part of their rotations). This curriculum is also integrated into individual and group supervision.

As part of the program, psychology, social work, nursing, and psychiatry faculty collaborate to enhance didactics, specialty training in evidence-based practices and programs, training rotations, supervision, and coaching for a predoctoral psychology internship program. Psychology interns participate in didactics with psychology, social work, psychiatry, and nursing trainees and collaborate clinically in schools with educators, mental health and health providers, and community partners. The didactics utilize course instructors and supervisors from multiple professions, and with diverse practice, research, and policy experience, to provide education and training experiences related to SMH, interprofessional collaboration, and cultural and linguistic competency.

Research. As part of the Center for School Mental Health rotation, the interns will work one day a week at the CSMH and will be involved in an array of research projects related to school mental health evaluation, quality improvement, and sustainability. Interns will be assigned to at least two projects at the CSMH and will be exposed to how research integrates into promoting best practices at local, state, and national levels in school mental health. Interns are required to conduct an independent research project during their internship year related to addressing the mental health needs of underserved and vulnerable youth and families that is integrated into their CSMH rotation. Interns are guided in their selection of a research supervisor, who supports the intern in their conceptualization, design, and completion of their research project. Interns are required to present the findings to their internship class and research mentors in preparation for sharing their findings with the larger SMH community. Specifically, interns are required to present posters and paper sessions at national conferences and/or publish their findings in peer-reviewed journals.

Policy. Interns participate in the advancement of SMH policy and programming as part of their CSMH rotation (1 day per week) via engagement in a number of CSMH projects, including monitoring of federal, state, and local legislation, development and dissemination of policy briefs, white papers, book chapters, and articles related to SMH policy, writing and dissemination of listservs, and developing resources related to SMH for dissemination to and use by state and local government and agencies (5 hours per week). Interns may also have opportunities to attend policy related meetings and conferences.

Population Served. The SMH Intern serves children between the ages of 5 and 19 years and their families. Although we see families from diverse ethnic and racial backgrounds, approximately 90% of clients are African-American. Typical presenting problems of students receiving individual, group, and family services include: depression, anxiety, posttraumatic stress, disruptive behaviors, family conflict, peer conflict, bereavement, abuse and neglect, family and community violence, substance abuse, and educational challenges.

Support from Literature. Comprehensive school mental health involves the delivery of a full continuum of mental health services and strategies (from mental health education and promotion to intensive intervention) to trainees in both regular and special education, in partnership with families, schools and communities. It builds on existing school programs, services, and strategies and prioritizes the use of high quality evidence-based practices and programs (Weist & Paternite, 2006). In an effort to improve access to care and meet the needs of children, schools have increasingly become a primary site for mental health services and a prevalent service delivery model of mental health care for children and adolescents (Kazak et al., 2010). Further, several national associations, including the American Psychological Association, the American Federation of Teachers, and Mental Health America, as well as numerous researchers and practitioners, have publicly stated support for increasing access to high quality mental health services in schools (Astor et al., 2012). The Center for School Mental Health at the University of Maryland (UMB) School of Medicine (SOM), has been instrumental in the leadership and facilitation of the UM SMH internship program, has been strategically involved in the drafting of a press release and has publicly voiced their support for the adoption of comprehensive school mental health services (Astor et al., 2012). A presidential-appointed task force and President Obama have endorsed the need for increased mental health care in schools (White House, 2013).

It is argued that schools are second only to families in shaping children's development (Cowen et al., 1996) and, therefore, make an ideal treatment setting. Because of the co-location of mental health services within a school setting, many of the traditional barriers to care (e.g., access, stigma, and continuity) are significantly reduced allowing for an enhanced access to mental health services for youth (Nabors & Reynolds, 2000). Research indicates that although only 16% of all children receive mental health services, 70 to 80% of those receiving care do so in the school setting (Rones & Hoagwood, 2000).

Integrating mental health services within the school also promotes a natural, ecologically grounded approach to helping children and families (Atkins, Adil, Jackson, McKay, & Bell, 2001). That is, youth and families are able to access services in their own community, providers are able to work with youth in a natural setting, and interventions can be implemented and monitored in an environment where youth are actually experiencing dysfunction. Given this ecologically grounded approach, treatment gains are more likely to be generalized and maintained (Evans, 1999). Some reasons for this improved generalizability include that when providers are based in schools they are better able to observe problem behaviors as they occur rather than rely on retrospective reports, can better manage contingencies in the environment, and can provide better guidance on alternative behaviors that are likely to be successful in

the school environment. A priority for the SMH track is the delivery of evidence-based practices and programs in partnership with families, schools, and communities. The CSMH and its faculty and staff have led clinical research, training and policy efforts to advance best practices related to SMH family engagement (Brandt, N., et al., 2014), workforce development for educators (Gibson, J., Stephan, S., Brandt, N.E., & Lever, N., 2014), education/mental health research (Stephan, S. et al., 2012), and preservice training for clinicians (Lever, N., Lindsey, M., Grimm, L., & Weist, M., 2014).

Given the emphasis on prevention in the school mental health model, the capacity for school mental health providers to engage in prevention and mental health promotion is increased (Weare, 2000). Most, if not all, youth in the school building can benefit from services that highlight healthy and positive behaviors. The presence of school mental health programs has been associated with improved school climate where trainees and teachers reported that they felt they were in a positive learning environment (Bruns, Walrath, Siegel, & Weist, 2004). In addition, Bruns and colleagues (2004) found that SMH has been associated with a reduction in inappropriate special education referrals. Teachers in schools with SMH programs were less likely to refer trainees to the special education eligibility process because of emotional or behavioral problems. The positive effects may be due to a perception that resources are available to support teachers and to help trainees who have emotional and behavioral problems.

An average student enrolled in a social and emotional learning program ranks at least 10 percentile points higher on achievement tests, has better attendance and classroom behavior, likes school more, has better grades and is less likely to be disciplined (Shriver & Weissberg, 2005). In addition to school related outcomes, school mental health programs have also been associated with high service satisfaction by trainees and families (Nabors & Reynolds, 2000). SMH services have been demonstrated to be effective on an individual level and increasingly there is a recognition of the importance of using evidence based programs and practices and effectively documenting outcomes. In a national survey of ESMH programs, 63 percent of respondents reported using evidence based practices as part of their work. Advancing evidence-based practices and programs and developing effective models for supervision, coaching, and training that support evidence-based work are key priorities of the Center for School Mental Health.

The following centers/programs are affiliated with the SMH internship. Brief descriptions of the programs are provided below.

- Center for School Mental Health (CSMH): The CSMH is co-directed by Drs. Nancy Lever and Sharon Hoover. The CSMH is the only federally-funded (HRSA) SMH program, research, and policy analysis center. Its mission is to *strengthen policies and programs in ESMH to improve learning and promote success for America's youth*. The CSMH is co-leading, with the School-Based Health Alliance, the School Health Services National Quality Initiative (NQI). The NQI strives to advance accountability, excellence and sustainability for school health services nationwide by establishing and implementing an online census and national performance measures for school-based health centers and comprehensive school mental health systems. As part of these efforts the Center has developed the School Health Assessment and Performance Evaluation (SHAPE) System to help improve the quality and sustainability of school mental health systems in the United States. The Center works at local, state, and national levels to advanced research, training, policy, and practice in SMH. Interns are involved in and lead numerous projects, such as advancing the literature and best practices needed to address trauma, documenting the quality and effectiveness of SMH services, increasing family engagement in mental health services delivered in schools, and advancing the SMH workforce by developing

curriculum and training materials. Other opportunities for interns include grant writing (e.g., for federally funded projects, private foundations, and state and local projects), writing book chapters and peer-reviewed journal articles, preparing content for the listserv, and critically reviewing articles for leading SMH journals. Additionally, interns have the opportunity to contribute to the ongoing mission of the CSMH through helping to develop practical resources for educators, youth, families, and mental health providers, as well as authoring issue briefs and articles geared toward enhancing the dissemination of best practice and research in SMH.

- School Mental Health Program: The School Mental Health Program is led by Dr. Nancy Lever, Executive Director, Jennifer Cox, LCSW-C, Program Director, Kelly Willis, LCSW-C, Associate Director, Dr. Sharon Hoover, Senior Advisor, and Dr. Brittany Patterson, Faculty Advisor. The SMHP is a longstanding (established in 1989), interdisciplinary outpatient mental health program that provides high quality comprehensive school mental health services (promotion, prevention, intervention, consultation) to youth and families in 25 Baltimore City schools working in close collaboration with families, schools, and communities. The SMHP has achieved national recognition for its commitment to advance access to high quality mental health care in schools. Baltimore was among the first nationally to develop school-based health centers, and has become a leader in the systematic development of comprehensive school mental health programs. The SMHP staff is comprised of licensed social workers, professional counselors, psychologists, and graduate trainees (social work, psychology, counseling, psychiatry, nursing). The SMHP is one of four lead programs in Baltimore City providing SMH services. SMH services augment the work of school-employed mental health providers, are available to youth in both general and special education, offer a full continuum of mental health services within the school, and are intended to reduce barriers to learning and promote student success. The SMHP is committed to implementing evidence-supported practices and programs across the Public Health Triangle. With many faculty within the SMHP having expertise in several evidence-based practices and programs (e.g., Modularized Practice/Common Elements, Coping Power, CBITS, FRIENDS), there are numerous opportunities for specialized training and skill practice.
- The Family Informed Trauma Treatment Center (FITT): The director of the Family Informed Trauma Treatment Center (FITT) Center is Dr. Laurel Kiser, the mission of the FITT Center is to develop, implement, evaluate, and disseminate family-based interventions for urban and military families to support positive outcomes for children and families who have experienced chronic trauma and stress. The FITT Center is part of the National Child Traumatic Stress Network (NCTSN) and one of 15 Category II Centers nationwide. In 2000, under the leadership of the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS), the NCTSN was established to raise awareness of the impact of childhood trauma and increase access to effective trauma treatments for thousands of our nation's children and adolescents. NCTSN chose the FITT Center to serve as a national expert on the role of families in the lives of children impacted by trauma and to further the availability of effective family trauma treatments. The FITT Center will lead the education, training, supervision, and coaching of clinicians related to effective family informed trauma treatment for children and adolescents, including intensive training and coaching in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Strengthening Families Coping Resources (SFCR). Supervision related to TF-CBT will be provided by Vickie Beck, RN, a national certified TF-CBT trainer.

Child Psychology: Maryland Psychological Assessment Clinic Rotation

All child interns participate in the Maryland Psychological Assessment and Consultation Clinic (MPACC) which offers a year-long experience providing assessment and consultation services to children and adolescents served through outpatient programs within the University of Maryland. Interns will spend approximately six hours per week in this clinic. Their time will be devoted to participating in training and supervision, conducting psychological assessments of children and adolescents (ages 2 to 18), conducting daycare/school observations, consulting with school and treatment staff, scoring, interpreting and writing reports, and providing feedback to families and treatment teams. Each intern will be responsible for 6 assessments over the course of the year. Clients are typically referred to MPACC from child and adolescent mental health programs in the University of Maryland System, including the 701 Outpatient Clinic, the School Mental Health Program, and the clinic that serves families of university employees.

Assessments & Supervision. MPACC referral questions are very diverse and can include differentiating between the breadth of clinical disorders and screening for learning problems, and making recommendations for school and treatment services. Tests administered include, but are not limited to: Autism Diagnostic Observation Schedule-2 (ADOS-2), NEPSY-II, Wechsler Intelligence Tests (WPPSI-IV, WISC-V, and WAIS-IV), Wechsler Individual Achievement Test-III and Woodcock Johnson IV - Tests of Achievement, Vineland Adaptive Behavior Scales, and a wide variety of behavior checklists. Feedback sessions involve the family and referring clinicians and emphasize the strengths and needs of the children and families.

During the first two months of internship, interns will complete intensive training in the Autism Diagnostic Observation Schedule-2 (ADOS-2) and spend time practicing the assessment. Interns will also have other targeted trainings during the year on assessment topics. Brittany Patterson, Ph.D., will provide weekly supervision of interns and co-lead diagnostic interviews and feedback sessions with interns and review and provide feedback on assessment reports.

UM School Mental Health Track Supervisors' Training and Experience

Vickie Beck, A.P.R.N., B.C., She has almost over 35 years of experience as a clinical nurse specialist working with abused children and their parents. She is a nationally certified TF-CBT trainer, leading training and ongoing coaching for licensed clinicians and University of Maryland child and adolescent trainees. Ms. Beck provides trauma focused supervision and support to all child interns.

Jill Bohnenkamp, Ph.D. is an Assistant Professor at the University of Maryland School of Medicine and Center for School Mental Health. She received her Ph.D. in Clinical and School Psychology from the University of Virginia, Curry School of Education in 2012. Dr. Bohnenkamp completed her pre-doctoral internship at Children's National Medical Center in Washington, D.C., and postdoctoral fellowship at the national Center for School Mental Health at the University of Maryland School of Medicine. Dr. Bohnenkamp provides clinical assessment supervision in the Maryland Psychological Assessment and Consultation Clinic (MPACC) and individual and group clinical, research and policy supervision to school mental health and early childhood school mental health interns. Dr. Bohnenkamp's research interests focus on behavioral and academic outcomes of school mental health service provision, school

mental health workforce development, mental health training for educators and pediatric primary care providers and increased access to mental health services for youth and families.

Elizabeth Connors, Ph.D., is Assistant Professor at the University of Maryland School of Medicine and Center for School Mental Health. She received her Ph.D. in clinical psychology, with concentrations in community and child psychology, from the University of Maryland Baltimore County in 2014. Dr. Connors completed her pre-doctoral internship in the School Mental Health Track of the VAMHCS/UM SOM Psychology Internship Consortium, and currently provides supervision and support to interns on research, policy and practice activities within the Center for School Mental Health, including providing guidance on intern research projects. Dr. Connors' research interests focus on dissemination, implementation and program evaluation of evidence-based mental health services for children and families receiving care in school and community-based settings. She is trained as an Improvement Advisor for the CSMH's National Quality Initiative's Learning Collaborative on Comprehensive School Mental Health.

Kay Connors, L.C.S.W., is the Co-Director of the Center of Excellence for Infant and Early Childhood Mental Health and the project director for the Family Informed Trauma Treatment Center, and has over 30 years of experience working with traumatized children and their families. Ms. Connors has provided mental health treatment to children and families in a variety of settings, including hospital, residential treatment, private practice, clinic, and home-based programs. Ms. Connors has directed programs, supervised staff, participated in outcome research as well as trained trainees and audiences locally and nationally in infant and early childhood and trauma treatments.

Dana Cunningham, Ph.D., is the Coordinator of the Prince George's School Mental Health Initiative (PGSMHI) and is involved in intern research and training. The PGSMHI is designed to provide intensive school-based counseling and supports to trainees in special education. Dr. Cunningham graduated from Southern Illinois University at Carbondale with a doctoral degree in Clinical Psychology in 2004. Following the completion of her internship at the VAMHCS/UM SOM Psychology Internship Consortium, she completed a two-year postdoctoral fellowship at the Center for School Mental Health. She is currently an Assistant Professor in the Department of Psychiatry. Dr. Cunningham's research and clinical interests are in the area of resilience, empirically supported treatments for ethnic minority youth, and school mental health.

April Donohue, Ph.D., received her Ph.D. in clinical psychology from Northern Illinois University in 2011. She completed her clinical internship at the University of Maryland School of Medicine, and then joined the staff of the child outpatient clinic in 2011. She provides teaching and supervision to trainees in the Division of Child and Adolescent Psychiatry..

Sharon Hoover, Ph.D., received her Ph.D. in clinical psychology from the University of Maryland Baltimore County in 2002, completing her clinical internship and two-year postdoctoral fellowship at the University of Maryland School of Medicine at the Center for School Mental Health (CSMH) and the School Mental Health Program. She is the Co-Director of the CSMH and an Associate Professor in the Department of Psychiatry. Dr. Stephan's clinical and research focus is in the implementation of empirically-supported interventions in schools, with a particular emphasis on serving traumatized youth and youth from health-disparate populations. She conducts research and clinical training in the areas of mental health-primary care collaboration and integration, quality

assessment and improvement, co-occurring disorders, school transitions, and trauma. She provides research and clinical supervision within the SMH track.

Laurel Kiser, Ph.D., M.B.A., received a Ph.D. in psychology from Indiana University and a M.B.A. from the University of Memphis. She completed internship and two years of post-doctoral training in child clinical psychology. She is an Associate Professor in Psychiatry at UMB. Dr. Kiser's career focus has been on the provision and evaluation of treatment for youth living in poverty, victims of neglect, physical and sexual abuse, with moderate to severe psychiatric and behavior disorders. Her research is on the protective role of rituals and routines for coping with trauma and she is supported by an NIMH K-23 Award for developing a manualized, multi-family skills-based intervention for traumatized families. Dr. Kiser is co-Principal Investigator of the National Child Traumatic Stress Initiative Category II Family Informed Trauma Treatment (FITT) Center. Clinically, she co-directs the Trauma Clinic and serves as the Psychologist supervisor for the Center for Infant Study. Dr. Kiser is also active in teaching and supervising Division trainees on childhood trauma in multiple venues. She provides trauma education in community settings for clinicians on assessment and treatment of young children impacted by violence exposure.

Nancy Lever, Ph.D., is the Co-Director of the Center for School Mental Health, Director of the University of Maryland School Mental Health Program, and an Associate Director of the VAMHCS/UM SOM Psychology Internship Consortium. She completed her undergraduate degree in psychology at Dartmouth College and her doctoral training in clinical psychology at Temple University. She completed her child internship and SMH postdoctoral training at the University of Maryland School of Medicine before joining the Department of Psychiatry in 1998. She is an Associate Professor in the Division of Child and Adolescent Psychiatry. She has been very active in promoting training related to SMH and has coordinated training experiences for psychology interns, psychiatry fellows, and postdoctoral fellows. She has presented and written extensively about school mental health and leads local, state, and national efforts related to advancing school mental health quality and sustainability. Research interests include: quality assessment and improvement, dropout prevention, workforce development, promoting resiliency, substance use prevention, and trauma-informed care. She oversees the SMH track and provides clinical and research supervision and training.

Brittany Patterson, Ph.D., received her Ph.D. in school and counseling psychology from the University of Buffalo. She completed her internship with the VA/UMB Consortium and her postdoctoral fellowship with the Center for School Mental Health (CSMH). She is an Assistant Professor at the University of Maryland School of Medicine, Center for School Mental Health (CSMH) and Director of the Maryland Psychological Assessment and Consultation Clinic (MPACC). Her clinical and research interests involve effective development and implementation of evidence based mental health programs in underserved schools and their surrounding communities. In her current role as a clinical faculty member with experience in school-based services, Dr. Patterson serves as a primary point person for training and technical assistance both within the school mental health clinical programs as well as to school stakeholders. Specific experiences include developing and delivering in-service curricula for mental health providers, teachers, school resource officers, parents, and school staff with emphasis on trauma informed care, safe and supportive learning environments, and positive school climate. Dr. Patterson provides research and clinical supervision within the SMH track, as well as, clinical supervision and training related to child and adolescent assessment.

Cindy Schaeffer, Ph.D., received her doctorate in Child-Clinical Psychology (with a concentration in Community Psychology) from the University of Missouri in 2000 and completed her clinical internship with the University of Maryland's School Mental Health Program. After a postdoctoral fellowship in Prevention Science at the Department of Mental Health within the Johns Hopkins Bloomberg School of Public Health, she held faculty positions at the University of Maryland Baltimore County and the Medical University of South Carolina before joining the Center for School Mental Health in 2015, where she is an Associate Professor. Dr. Schaeffer serves as a research mentor within the child track. Her research interests relate primarily to developing and evaluating multifaceted ecologically-based interventions for youth involved in the juvenile justice and child protective service systems and their families. Her current work involves adapting Multisystemic Therapy (MST) for CPS-involved families experiencing substance abuse and domestic violence, and developing a mobile phone app that supports parental management of youth with conduct problems. She is also working to promote effective alternatives to school suspensions and other school push-out policies that contribute to youth juvenile justice involvement.

Rebecca Vivrette, Ph.D., is an Assistant Professor and Clinical Psychologist in the Division of Child and Adolescent Psychiatry. She received her Ph.D. in Clinical Psychology with an emphasis in Multicultural and Community Psychology from the California School of Professional Psychology in 2014. She completed her clinical internship and postdoctoral training at the University of Maryland School of Medicine. Dr. Vivrette specializes in early childhood mental health treatment, assessment, and research, with particular focus in caregiver mental health and child traumatic stress. She has been trained in a variety of evidence-based treatment models, including TF-CBT and Child Parent Psychotherapy (CPP), as well as developmental assessment measures, including the Bayley Scales of Infant and Toddler Development. Dr. Vivrette serves as the Assessment Co-Coordinator for the VAMHCS/UMB Internship Consortium Training Committee

Minor Rotations

We offer several minor rotations which vary in their duration and workload. The specific minors that are offered vary from year to year, depending on staff resources and institution needs.

Diversity Minor

Introduction

The Diversity Minor Rotation was developed in the spirit of integrating diversity more fully into the training experience. As psychologists, we are tasked with the ethical responsibility of providing culturally informed and appropriate treatments for our clients and the communities with which we engage. However, clinicians often cite concerns about their abilities to apply knowledge of diversity to daily practice. This minor rotation will provide interested interns an opportunity to bridge the gap between knowledge and application.

Core Components

The Diversity Minor Rotation was designed to be flexible, allowing interested interns an opportunity to create an experience fitting with personal and professional goals, prior training experience, and expectations. This is also consistent with a multicultural psychology approach, in which the client is seen as an expert collaborating in their treatment. Generally, though, an intern would participate in this

rotation for a period of six months to a year and approximately three to six hours per week. Core components include the following:

1. *Development of a year-long project, culminating in a presentation for your peers, supervisors, and VA psychologists.* The nature of this project will be determined by the intern in collaboration with the rotation supervisor, but may include an administrative project, consultative service, clinical training delivery, psychotherapeutic intervention, development of a paper, program evaluation/needs assessment, etc.
2. *Participation in the VAMHCS Mental Health Diversity Committee.* This multidisciplinary committee aims to integrate diversity into the spectrum of activities in which VAMHCS mental health employees engage.
3. *Maintenance of the VAMHCS Virtual Cultural Resource Center (VCRC).* The VCRC is an on-line database consisting of seminal diversity and multicultural literature and resources, which is made available to VAMHCS Mental Health staff.

Objectives

Upon completion of the Diversity Minor Rotation, interns will understand more deeply the necessity for a more inclusive practice of psychology. Interns will have working knowledge of the general concerns within the field of multicultural psychology as well as specific challenges implementing culturally-based approaches to treatment and research in a large medical setting. Interns will have developed a particular skill-set in the application of multicultural psychology, as a result of participation in supervision and developing a specific expertise with regard to their year-long project.

Supervision

Supervision will be conducted using a motivational enhancement and multicultural approach, emphasizing how best to apply empirically supported treatments to a diverse, urban population. The frequency and intensity of supervision will vary, based on the intern's level of experience and training. An intern would be expected to meet for face-to-face supervision once a week for one hour; administrative or research projects may be less frequent, depending on need and developmental level of the trainee. Spot supervision will be available as well.

Supervisor's Training and Experience

Dr. Jade Wolfman-Charles, a VAMHCS Supervisory Staff Psychologist and the Psychology Training Program Director, completed her degree in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Charles has specialized training in evidence based practices including Cognitive Behavioral Therapy, Motivational Interviewing/Motivational Enhancement Therapy, Acceptance and Commitment Therapy and Cognitive Processing Therapy and serves as a Consultant and Regional Trainer for the VA National Motivational Interviewing Initiative.

Dr. Erika White completed her graduate training at Saint Louis University, obtaining a Ph.D. in Clinical Psychology. Her dissertation research addressed the perpetration of racial microaggressions in a cross-racial counseling dyad. Her predoctoral internship was completed at the Washington, D.C. VAMC. She completed ten months of a postdoctoral fellowship at the Pittsburgh VA from October 2010 to August 2011. Dr. Morton has worked as a staff psychologist in the Trauma Recovery Program since August 2011. Since this time, she has become coordinator of the PTSD Assessment Clinic and has worked with colleagues to implement the VAMHCS Mental Health Diversity Committee and Diversity Seminar Series. Dr. Morton greatly values training and enjoys the supervision of trainees from all levels. She continues to be interested in increasing the multicultural awareness of trainees and staff and offering evidence-based psychotherapy to Veterans diagnosed with PTSD.

Military Sexual Trauma (MST) Minor

Introduction

The MST Minor Rotation was developed for interns who are interested in learning about the unique aspects of working with Veterans who have experienced MST. This minor rotation offers the opportunity to co-lead an all males MST group or an all females MST group. These groups are semi-structured in that they teach healthy ways of coping with difficulties common after MST, while also allowing Veterans with MST to connect with individuals who have had a similar experience. Interested interns may also have the opportunity to provide individual, evidence-based psychotherapy related to symptoms of PTSD, depression, or insomnia with Veteran(s) with MST. Finally, opportunities related to management of consults and/or program evaluation may be available as well.

Core Components

The MST Minor Rotation is designed to be flexible, allowing interested interns an opportunity to create an experience fitting with personal and professional goals. However, a core component of this minor rotation would be co-leading a semi-structured, 12 session all women, or all male, MST group. Generally, an intern would participate in this rotation for a period of at least five months but could participate for the full year. This minor rotation would involve approximately three to six hours per week.

Objectives

Upon completion of the MST Minor Rotation, interns will understand more deeply the unique mental and physical health difficulties of Veterans who have experienced MST. Interns will also develop comfort in co-leading semi-structured, 75-90 minute groups with this population that are designed to both teach healthy coping skills and to offer Veterans opportunities to connect with other Veterans with a similar experience. Finally, there is the opportunity for exposure to the administrative task of managing consults and connecting Veterans who have experienced MST with appropriate mental health care.

Supervision

Supervision will be conducted using a developmental approach, based on the intern's previous training experience with this population and specific treatment modalities. An intern would be expected to meet for face-to-face supervision once a week for one hour. However, spot supervision will be available as well.

Supervisor's Training and Experience

Christine Calmes, Ph.D. received her doctorate from the State University of New York-Buffalo and completed her pre-doctoral internship at the University of Maryland/VA Maryland Healthcare System (VAMHCS) consortium through the VA serious mental illness track. She completed one year of a post-doctoral fellowship through the MIRECC prior to taking a staff psychologist position in the Psychosocial Rehabilitation and Recovery Center (PRRC) at both Baltimore and Perry Point VA's. Several years ago, Dr. Calmes transitioned to a staff psychologist position in the Trauma Recovery Program (TRP) and has worked at the Perry Point and Baltimore VA TRP programs. Dr. Calmes serves as the Military Sexual Trauma Coordinator (MST) for the VA Maryland Healthcare System. Given her training and clinical experiences, Dr. Calmes has a special interest in treating Veterans with PTSD and comorbid serious mental illness, as well as Veterans with MST. Dr. Calmes primarily provides trauma-focused interventions, including Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) to Veterans. Dr. Calmes is a VA provider of Cognitive Processing Therapy (CPT), Motivational Interviewing (MI), Interpersonal Psychotherapy (IPT) for depression, and Cognitive Behavioral Therapy for Insomnia (CBT-I).

EFT Couples Therapy Minor

The minor rotation is designed to give interns the opportunity to learn an empirically supported approach to working with couples. Interns will learn Emotionally Focused Couples Therapy (EFT) developed by Sue Johnson, Ed.D. This evidenced based treatment is based on the integration of attachment theory, humanistic psychology and systems theory. During the summer, interns will discuss EFT literature, use the EFT training workbook, review and discuss professional training tapes and will develop and practice skills thru small group discussion and role plays. During the course of the year, the clinician will work with one or two couples. There will be weekly group supervision and scheduled individual supervision. Supervision modalities include discussion of the case and review of videotaped sessions. The minor requires an intern to commit to 5 hours a week for a full year. The treatment population will be couples who have the psychological resources to benefit from this course of treatment. These Veterans will usually be relatively higher functioning and may have a wide range of possible diagnoses.

Supervisors' Training & Experience

Dr. Neil Weissman has been an attending psychologist for the VA since 1992 and has supervised interns for these 19 years. He has completed a post-doctoral fellowship in the treatment of SMI from Sheppard Pratt and has received specialized training in CBT from the Beck Institute in Philadelphia. Dr. Weissman is also a certified supervisor in Emotionally Focused Couples Therapy from the International Center for Excellence in Emotionally Focused therapy.

Minor Rotation in Family Intervention Team (FIT)

This minor rotation is designed to offer psychology interns the opportunity to develop competencies in working psychotherapeutically with families and couples within a number of evidence-based practice frameworks. Interns participating in this minor rotation can expect to master utilization of the following evidence based family therapy practices officially endorsed and widely utilized by the VA system nationally: Integrative Behavioral Couple Therapy (IBCT), Behavioral-Couples Therapy for Substance Use Disorders (BCT-SUD), and Behavioral Family Therapy (BFT).

Integrative Behavioral Couple Therapy (IBCT) was developed and empirically validated by Drs. Andrew Christensen and Neil Jacobson (2000) to promote the dual goals of greater emotional acceptance and concrete change as positive outcomes for couples. IBCT boasts a variety of treatment strategies tailored for each couple based on a rich and textured case conceptualization developed within the assessment phase of treatment. During the formal treatment phase, strategies to promote acceptance and change are consistent with other behavioral treatments, yet are elegantly evocative in nature rather than prescriptive. Couples who engage in IBCT tend to make concrete changes to accommodate the new acceptance they've gained of their partners' emotional needs.

Behavioral Couples Therapy for Substance Use Disorders (BCT-SUD) is a first-line treatment for substance use disorders according to VA/ DoD practice guidelines. Developed by Drs. Timothy O'Farrell and William Fals-Stewart (2006), BCT-SUD has demonstrated within randomized studies, compared to individual treatment alone, that it leads to significantly greater substance use treatment outcomes and facilitates greater relationship adjustment following treatment. BCT-SUD is designed to offer, within its structured 12-session protocol, additional support for sobriety, increased relationship satisfaction, and instruction on effective communication skills.

Behavioral Family Therapy (BFT) was designed by Drs. Kim Mueser and Shirley Glynn (1999) specifically to offer support, psychoeducation, and communications skills training for families and their loved ones who've been diagnosed with a Serious Mental Illness. This intervention has demonstrated within empirical studies significant reductions in psychiatric symptoms, increases in quality of life for both the identified patients and their families, and improvements in family cohesion.

Other FIT treatment modalities in which psychology interns may have the ability to gain some experience within the training year include: Brief Family Consultation (1 – 3 session intended to determine family needs and offer recommendations); Parenting Training educational classes (utilizing a curriculum developed by the Military Child Education Coalition/ MCEC); Cognitive-Behavioral Couples Therapy for PTSD (developed by Dr. Candace Monson); and Structured Approach Therapy for OEF/ OIF Veterans with PTSD (developed by Dr. Frederic Sautter).

Psychology interns will meet individually with Dr. Korobkin for 1 hour of supervision at least once a week and are expected to audio tape sessions from at least 2 IBCT cases and 1 BCT-SUD case during the training year. Dr. Korobkin will then be able to offer specific feedback on these tapes within the supervision. There are also opportunities for the following: Additional group supervision (with FIT psychology extern and Dr. Korobkin), case presentations within the FIT weekly team meetings, video recording of sessions and Live Supervision (as possible).

Supervisor's Training and Experience

Samuel B. Korobkin, Ph.D. is the Coordinator of the Psychology Externship Program at the VA Maryland Health Care System (VAMHCS) and provides direct care services to Veterans and their families as the full-time clinical psychologist for the VAMHCS Family Intervention Team (FIT). He also serves as a VA Central Office national consultant for the Integrative Behavioral Couple Therapy (IBCT) evidence based practice roll out initiative. As such, he offers consultation and certification to VA licensed independent practitioners nationally in the provision of IBCT services. He is further serving as a Subject Matter Expert and consultant for the VISN5 MIRECC Wellness Recovery Action Planning (WRAP) pilot study. Additionally, he maintains a part-time private practice providing adult individual and couples psychotherapy. Dr. Korobkin completed his Bachelor's degree at University of Maryland Baltimore County, and his Master's and Doctorate degrees in Clinical Psychology from St. John's University in New York. He completed a pre-doctoral internship at the Baltimore VA Medical Center and a post-doctoral fellowship at the West Los Angeles VA Medical Center. He has worked in various medical and private practice settings both in California and Maryland and has served as a clinical supervisor for psychology interns and externs. Dr. Korobkin's specific clinical interests include couples and family psychotherapy and recovery-oriented interventions.

Long Term Psychoanalytic Supervision Rotation

The minor rotation is a long term psychotherapy supervision designed to provide a year-long experience in structured supervision in the conceptualization and treatment of long term clients. Interns will have the ability to choose between psychoanalytic supervision or evidence-based treatments such as ACT, CBT, or Interpersonal Therapy. Interns will see at least one patient throughout the year, and participate in one hour of supervision with a licensed clinical psychologist. Clients are provided through referrals through the Mental Health Clinic. Supervision occurs at the Baltimore VA Medical Center.

Supervisor's Training & Experience

Dr. Mark Nolder received his Ph.D from Texas Tech University in 1990. He completed a clinical internship at the Audie L. Murphy VA Medical Center in San Antonio, Texas. He is currently a staff psychologist in the outpatient program at the Fort Howard Community Based Outpatient Clinic. He is also an Adjunct Professor at Towson University and has his own private practice in Harford County. Dr. Nolder's research and clinical interests include: Psychoanalytic metapsychology, evidence-based psychoanalytic psychotherapy, evidence based

psychotherapy relationship factors, psychotherapy supervision, psychology of music, individual psychoanalytic psychotherapy.

Dr. Candice Wanhatalo received her Ph.D. from George Mason University. Prior to joining VAMHCS in April, Dr. Wanhatalo was a staff psychologist in the Mental Health Clinic at the Washington DCVAMC for ten years. During her ten years in DC, Dr. Wanhatalo was an active member of the training committee, served as supervisor to externs and interns and assisted in the creation of the Special Populations fellowship, where she was primary supervisor for the Geropsychology track. She has clinical interests in Geropsychology, Whole Health, mindfulness, and anger management. She has completed additional training in evidence-based approaches such as CBT for Depression, CBT for Psychosis, and Interpersonal Therapy for Depression.

Enhanced Research Minor

In keeping with the Consortium's scientist-practitioner model of training, the Enhanced Research Minor rotation was developed to provide Doctoral Interns interested in pursuing primarily research-focused fellowships and careers an opportunity to obtain enhanced research training and mentorship, above and beyond that which is expected within the core research requirement. The American Psychological Association (APA) Commission on Accreditation (CoA) specifies that the Internship year shall focus primarily on training in the practice oriented areas of health service psychology. The Association of Psychology Postdoctoral and Internship Centers (APPIC) further delineates that at least 25% of trainees' time is in face-to-face psychological services to patients/clients. As clinical training is the focus of the Internship year, Interns interested in participating in the Enhanced Research Minor must be able to demonstrate that the APA and APPIC clinical training requirements have been met and that these requirements continue to be met throughout the Internship training year.

Core Components

Interns interested in the Enhanced Research Minor should be able to demonstrate a pattern of dedication to scientific study as well as a path toward a research career. The specific components of the research minor are flexible and will vary based on Interns' backgrounds, experiences, and research-related training goals. However, each Intern should explicitly address how participation in the Enhanced Research Minor will contribute to skill development/refinement (e.g., analytic technique, grant writing, manuscript preparation, etc.) and expansion of professional capacity (e.g., participation in research center/group meetings, attendance at UM/ VAMCHS research-related symposia, etc.). Upon completion of the Enhanced Research Minor, selected Interns will be able to demonstrate a significant contribution to research activities within the host organization(s). Such contributions should be in addition to the expectations outlined as part of the core research project required of all Consortium Interns.

Interns participating in the Enhanced Research Minor will:

- Provide a brief outline of research interests and goals along with an updated CV, which will be used to determine fit with a research supervisor
- Dedicate a minimum of 12 and a maximum of 14 hours per week to research activities which may include activities more typically considered clinical in nature – e.g., delivery

of an intervention within a research study; attendance at research-related workshops and talks, etc.)

- Please note that for some Interns the core research project will be subsumed by the Enhanced Research Minor and for other interns it will be separate. This determination is based upon a combination of Intern interests, as well as research opportunities and mentor availability/interest. If the Enhanced Research Minor is separate, the total amount of time allocated for the minor will be 6-8hrs/week, to allow for up to 6 hours for the core Intern research project.
- Submit to the Training Committee, in consultation with their research supervisor, a brief outline that delineates the following:
 - focus of the project(s)
 - the intern's responsibilities
 - research-related goals (i.e., development/refinement of a new skill—e.g., processing of fMRI data, SEM, etc., attend research-related workshops, develop conference presentation, manuscript development, manuscript submission, development of an IRB submission, program evaluation project, grant submission, treatment development, dissemination projects, policy development, etc.)
 - method/frequency of supervision
- Be evaluated at least two times a year (mid-year and year-end) using the Research Competency Assessment Form, which should clearly indicate the specific research project goals and skills

Supervision

Potential research opportunities will be presented to Interns in the middle of July in a meeting with the Interns assigned Research Coordinator - Dr. Dux or Dr. Bohnenkamp. Every attempt will be made to tailor a research experience to the Intern's interests and goals, though this may not always be possible given research supervisor availability and project scope. The Intern will be responsible for contacting the potential supervisor(s) directly to discuss the possibility of working with them. The Intern may not end up with his/her first choice of a project, or of a supervisor. Thus, it is to the Intern's advantage to identify more than one possible project/supervisor. The general expectation is that Interns in the specialty tracks—trauma, neuropsychology, health psychology, SMI, Child/School—will work with a faculty member of those tracks on projects relevant to the specialty, but this is not a requirement. Once a research supervisor is selected, the expectation for supervision would be to meet weekly for a minimum of 1 hour.

The VISN 5 Administrative and Leadership Minor

This rotation is designed to provide interns with greater exposure to the operations of Mental Health services across the geographic area of VISN 5 (West Virginia, Maryland and District of Columbia). Psychologists are committed to promoting and enhancing patient care and well-being. Part of this work involves determining whether Veteran's needs are being met and

evaluating whether they are receiving the best quality of care. This rotation provides interested interns with the opportunity to learn about and actively engage in program development, oversight and evaluation from a regional perspective. Moreover, interns will have the opportunity to observe and participate in the activities of leadership staff to better understand health care at the macro level. Finally, this rotation is designed to provide potential methods of preparing for leadership opportunities in areas of clinical health care administration.

Supervisor's Training & Experience

Dr. Lowman currently serves as the Chief Mental Health Officer in Veterans Integrated Service Network (VISN) 5 where she oversees mental health operations for six VA Medical Centers throughout West Virginia, Maryland, and District of Columbia. She contributes actively to the profession of Psychology within VA through her membership on the National and VISN 5 Psychology Professional Standards Board and Association of VA Psychologist Leaders. She began her leadership role within VA while serving as the Women Veterans Coordinator and developed and managed numerous mental health programs at the VA Maryland Healthcare System throughout her career. While a Supervisory Psychologist and manager at VA Maryland Healthcare System, Dr. Lowman expanded access to mental health in the CBOCS by implementing Primary Care -Mental Health Integration (PCMHI) and utilizing telemental health to expand access in rural areas. Dr. Lowman received her Undergraduate and Doctorate Degree from the University of Delaware and State University of New York at Albany, respectively. She completed her internship at Baltimore VA in 1990 and joined the VA as a Clinical Psychologist in 1991. Dr. Lowman has 20 years' experience supervising pre-doctoral interns at the VA Maryland Healthcare System. Her professional interests include program development, Primary Care-Mental Health Integration, Telemental Health and leadership development for women.

Other administration minor experiences are also available in VAMHCS with mental health leadership, developing and implementing performance improvement initiatives and related program development, organizational goal setting and personnel management. Interns on the administrative minor also have a chance to engage in a leadership 360-degree rating process.

Motivational Interviewing/Motivational Enhancement Therapy Minor

“Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change (Miller & Rollnick, 2012).” Motivational Interviewing (MI) is an evidence-based treatment that is effective in many settings and for a variety of behaviors. MI is useful when a client is ambivalent about a change that is clearly in their best interest (for example smoking cessation; chronic disease management; substance use disorders; and engagement in, and adherence to, other treatments) to make.

One common adaptation of MI is Motivational Enhancement Therapy (MET), which involves assessment and feedback and is more structured. Recent reviews indicate evidence for the efficacy of MET as either a stand-alone treatment or as a prelude to further treatment for both alcohol and other drug abuse. MET can also increase treatment adherence and facilitate transition from one level of care to another across a range of problem behaviors.

Interns electing to participate in this Minor will learn and implement both MI and MET Interventions.

Core Components

The MI/MET Minor Rotation was designed to be flexible, allowing interested interns an opportunity to create an experience fitting with personal and professional goals, prior training experience, and expectations. Generally, though, an intern would participate in this rotation for a period of nine months to a year and approximately three to six hours per week.

Core components include the following:

- Participation in day-long MI workshop (usually scheduled in September)
- Participation in 3-months of MI Consultation Group (usually October – December)
- Participation in weekly group/individual supervision (1 hour/week)
- Submission of at least 6 recorded MI/MET client sessions
- Be evaluated at least two times a year (mid-year and year-end) using the Competency Assessment Form

Rotation Objectives/Goals

1. To demonstrate skillfulness with foundational motivational interviewing techniques and strategies.
2. To demonstrate an ability to effectively apply motivational interviewing concepts and tasks to a variety of patients and health behaviors challenges (i.e., smoking cessation, substance use disorders, exercise, weight management, medication adherence, treatment engagement, etc.).
3. To demonstrate an ability to provide normative feedback regarding substance use (and possibly other health behavior challenges) using motivational enhancement skills and strategies.

Supervisor's Training and Experience

Dr. Jade Wolfman-Charles, a VAMHCS Supervisory Staff Psychologist and the Psychology Training Program Director, completed her degree in Clinical and Community/Social Psychology at the University of Maryland, Baltimore County. Her research focused on individual and community level risk and protective factors of substance use with a specific focus on African Americans. Dr. Charles has specialized training in evidence based practices including Cognitive Behavioral Therapy, Motivational Interviewing/Motivational Enhancement Therapy, Acceptance and Commitment Therapy and Cognitive Processing Therapy and serves as a Consultant and Regional Trainer for the VA National Motivational Interviewing Initiative.

Research Training

The Consortium requires that interns actively engage in research that supports their ability to: 1.) identify and clearly describe the disorders and conditions presented by our patients, 2.) select or create reliable and valid outcomes measures that are sensitive to changes in the patient's disorder or condition, and 3.) identify and successfully administer treatments to improve these disorders or conditions.

To fulfill the core research competency requirement, it is expected that each intern complete a research project during the course of the training year. Supervisors for research activities include VA and UMB staff, including psychologists, psychiatrists, pharmacologists, and health economists. At the beginning of the year, each intern is matched with a research mentor with whom they will develop a research idea, plan a research project, and carry out the research. There is considerable flexibility in the content, scope, and focus of intern projects, however, it is expected that it will consist of a project independent of the

dissertation. Up to six hours per week can be used by interns as research time. Toward the end of the year, each intern presents the results of their research in a forum of their fellow peers and faculty. Many interns choose to participate in a poster presentation at the University of Maryland research colloquium, during which time they may present the results of their internship research or dissertation project. Many intern research projects have led to presentations at local, regional, and national research meetings as well as publications and ongoing collaborations. The research core competency requirement is coordinated by Moira Dux, Ph.D. and Jill Bohnenkamp, Ph.D.

Didactic Opportunities

Consortium Interns meet weekly for two and half hours of required didactic training through a comprehensive Consortium Seminar Series. The seminar series, coordinated by Dr. Juli Buchanan, is intended to expose interns to a wide range of clinical and research topics and to stimulate discussion and professional development. Topics include legal and ethical issues, assessment and treatment of various psychological disorders in children and adults, cultural competence, stigma, couples, family and group treatment modalities, as well as career development issues (*e.g.*, post-doctoral fellowships, job talks, licensure, research funding). Presenters are faculty and staff from the University of Maryland, the VA, and guest speakers from local universities and community organizations (such as the National Alliance for the Mentally Ill and the American Psychological Association). A sample schedule is provided in Table 5: Seminar Schedule (July-November).

Diversity Seminar Series

Embedded within the seminar series is a monthly diversity seminar, coordinated by Dr. Erika White, which is focused on topics that enhance interns' understanding of cultural competence within clinical and research applications. Topics are a blend of didactic material and experiential exercises, designed to enhance intra/interpersonal awareness, knowledge, and practical skills. Topics typically include military culture, disabilities, LGBTQI, race and privilege, spirituality, and microaggressions.

The objectives for the diversity seminar are to:

- provide an atmosphere in which interns and supervisors can explore themselves, their worldviews, and the worldviews of others, and how these beliefs might impact clinical work, scientific research, or professional development
- increase interns' awareness and understanding of cultural factors in diagnostic and therapeutic processes, and the research environment
- broaden interns' effectiveness in counseling and researching persons with diverse characteristics

Additional Didactic Opportunities

In addition to the required weekly seminar series, there are a number of intensive trainings and consultation groups in evidenced-based treatments that are offered to Consortium interns. These include, but are not limited to: Social Skills Training, Cognitive Processing Therapy, Prolonged Exposure, Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and Motivational Interviewing. Most trainings involve a formal workshop that is facilitated by a regional or national trainer, followed by a consultation group to assist in implementation of the treatment modality.

There are many other educational opportunities available at VA and UMB locations including departmental grand rounds, journal clubs, and various symposia. The VA MIRECC organizes a twice-monthly meeting (September through May) at which invited speakers and local researchers present research findings, discuss grants or other projects on which they are working to get input from peers, practice upcoming talks, or discuss other research-related issues. The UMB Division of Services Research journal club meets Fridays at noon to discuss articles on a range of mental health services topics, with special emphasis on methodology issues. There is also a journal club focused on cognitive neuroscience, with emphasis on schizophrenia, which meets at the Maryland Psychiatric Research Center. The School of Medicine Office of Faculty Affairs and Professional Development offers monthly Psychiatry Grand Rounds and seminars throughout the year on topics such as writing a

successful grant application, time management, and teaching methods. The schedule for these activities can be viewed here: <http://medschool.umaryland.edu/career/>. Last, each specialty track offers a didactics schedule specific to their specialty.