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Health Service Psychology Education and Training in the Time of COVID-19:

Challenges and Opportunities

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ABSTRACT

The COVID-19 pandemic has posed unprecedented challenges to health service psychology (HSP) education and training but also presents tremendous opportunities for growth that will persist well past the resolution of this public health crisis. The present paper addresses three aims in understanding the challenges and opportunities faced by the HSP education and training community. First, it describes challenges to HSP education and training created by the COVID-19 pandemic, including the need to maintain the integrity of training, facilitate trainee progress, continue clinical service delivery, manage the safety and wellbeing of trainees, faculty, staff, and clients/patients, and adhere to national and local emergency orders. Second, the paper summarizes guidance from training organization leadership regarding training program and clinical site responses to these challenges. Several principle-based recommendations called upon training programs to prioritize trainees and their training needs, while urging balance and flexibility in meeting the multiple demands of training programs, institutions, and the public. Third, the paper discusses key opportunities for improvement in HSP education and training, including more effective use of competency evaluations; distance technologies in therapy, supervision, and admissions; and re-consideration of internship and degree timing and HSP's identity as a health care profession; as well as the potential for comprehensive review and redesign of HSP education and training. Embracing these opportunities may help ensure that HSP education and training is preparing its graduates to meet the psychological healthcare needs of the future.

Keywords: Health Service Psychology, Education and Training, COVID-19, pandemic

Public Significance Statement:

The COVID-19 pandemic challenged health service psychology educators to continue clinical training and service delivery in the context of unprecedented health risks and community shutdowns. Creative responses to these challenges have highlighted opportunities for improvements in how health service psychologists are trained (e.g., in the use of distance technologies for admissions, therapy, and supervision; more effective use of competency evaluations), and in the role of health service psychology trainees as healthcare providers.

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Challenges and Opportunities

For most of the world's population the COVID-19 pandemic has been an unprecedented event. The novel virus (referred to as “severe acute respiratory syndrome coronavirus 2”, or “SARS-CoV-2”) that emerged in late 2019 was previously unknown to humans, highly infectious, and with no human immunity, spread globally over several months (Centers for Disease Control and Prevention: CDC, 2020). For the first time in United States history, all 50 states were at one point simultaneously under a disaster declaration (US News, 2020), with nearly 95% of Americans under stay at home orders to mitigate virus spread and manage physical health (Secon & Woodward, 2020). In addition to substantial economic, educational, vocational, and personal impacts, the effect of the pandemic and its aftermath on mental health will likely be extensive. Social isolation, financial and health insecurity, exposure to distressing media, and first-responder and caregiver stress and trauma may contribute to a range of acute psychological symptoms, as well as exacerbation of ongoing mental health challenges (Centers for Disease Control and Prevention, 2020; Garfin, Silver, & Holman, 2020; World Health Organization, 2020). These heightened and widespread mental health needs, in the context of an ongoing global pandemic that requires physical distancing and limits access to treatment, create an unprecedented challenge, responsibility, and opportunity for psychology.

With rapidly changing and uncertain conditions during the COVID-19 pandemic, the health service psychology (HSP) education and training community needed to transition quickly from “business as usual” to procedures needed to conduct critical tasks during emerging crises. Often, decisions made by local institutions constrained education, training, and service delivery, while HSP programs continued to prioritize the unique training needs of HSP trainees and

training programs. In this new situation with rapidly evolving information, competing demands, the need to make time-sensitive decisions, the paths forward were frequently unclear.

The purpose of this paper is threefold: (1) to describe challenges to HSP training created by the COVID-19 pandemic, (2) summarize guidance that training organization leadership developed regarding stakeholder responses to the identified challenges, and (3) discuss how lessons learned during the pandemic create opportunities for innovative and lasting improvement or even redesign of education and training, as well as practice, in HSP.

As leaders in HSP education and training across multiple practice areas (i.e., clinical, counseling, school psychology and combinations of these areas) and levels of training (i.e., doctoral, internship, and postdoctoral levels), the authors present a unique perspective on the HSP education and training response to the pandemic. Given the recency of the pandemic, information and experiences described throughout the paper were identified from largely informal sources (e.g., listserv discussions, training council meetings, consultations with trainees and training sites), which are admittedly more limited than systematic research. Many challenges and program responses were relevant across training levels; the general term “trainee” (i.e., vs. student, intern, or postdoctoral trainee) is used when referring to these cross-level issues. Although HSP faced challenges across the full range of education and training (e.g., development of knowledge, skills, and competencies in the scientific foundations of psychology, research, clinical practice, supervision, and consultation and interprofessional skills), the current paper focuses primarily on the impact of the pandemic on clinical practice training.

Challenges to Education and Training Presented by COVID-19

Amidst the COVID-19 crisis, stakeholders in HSP education and training faced challenging decisions that involved weighing the interests of the public (e.g., minimizing

disruption to clinical services), the institution where training occurs (e.g., maintaining capability to care for individuals served), the training program and its integrity (e.g., maintaining quality of training and continuity of learning experience), and individual trainees and their loved ones (e.g., guarding safety and wellbeing). Training programs and clinical training sites had varied responses to the COVID-19 pandemic due to geographic differences in infection rates, setting type, and individual institutional policies. Sites in and around New York, Seattle, and other initial virus “hot spots” in the United States were quickly faced with managing ill patients and attempting to mitigate virus spread. Many school districts and college campuses suspended in-person services, whereas inpatient hospitals and correctional facilities continued services while managing the virus in confined living quarters. Training programs were also variably impacted by state and local orders that governed essential versus non-essential activities, travel restrictions, maximum gathering size, and physical distancing requirements.

Although stakeholder responses varied, some trends were apparent. First, sites and trainees were instructed by accreditors and regulators to follow their institutions’ guidance as well as state and local orders (Baker et al., 2020). Institutional and governmental guidance and orders, however, were not always in place, clearly defined, or well-aligned with one another. Many training programs and trainees were left to determine their course of action with limited regulatory input. Initially, many training sites maintained clinical training and service delivery with basic accommodations, such as employing physical distancing, increasing availability of hand sanitizer, bolstering cleaning procedures in their buildings, and allowing, recommending or providing masks or other personal protective equipment (PPE). More intensive modifications such as working from home were often initially implemented only for individuals with personal

risk factors (e.g., compromised immune system) warranting extra protection from COVID-19 exposure. As confirmed cases of COVID-19 increased across North America in mid- to late March 2020, training council listserv discussions reflected that many training staff, especially those not in hospitals, either chose or were required to stop direct patient contact until telehealth training and implementation procedures were established. Similarly, programs developed distance education or other options to enable students, interns, and postdoctoral residents to continue to develop the knowledge and skills required for program completion and licensure.

Navigating multiple and potentially competing interests (e.g., institutional policies, requirements for licensure) in the context of an acute need for decision-making, with uncertainty about risks and consequences, challenged all HSP stakeholder groups. Several specific challenges were highlighted or exacerbated by the COVID-19 pandemic.

Defining Trainee Status and Roles. How sites perceived trainees – as students or employees, as essential providers or not – impacted decisions regarding continuity of work. In some instances, trainees were not allowed to continue their training if a site closed or the trainees or their activities were deemed non-essential. In other situations, trainees were considered essential employees and allowed or required to continue working. Although employee status may involve certain benefits superior to those without such status (e.g., pay, health benefits, leave time), if deemed essential, employees may be required to continue working or assigned new tasks during emergencies. Indeed, some sites required trainees to continue to provide in-person services, despite stay-at-home orders or federal rulings that made the provision of telehealth more accessible, or redeployed trainees to engage in tasks that were not part of HSP training but

were important to facility operations, such as front door screening for COVID-19 symptoms.

To understand the implications of a student vs. trainee designation, it is essential to consider HSP trainees' professional standing with respect to degree and licensure. The bulk of HSP clinical practice training – practicum and internship – occurs while the trainee is still a pre-degree student, and for all levels of training the Standards of Accreditation (SoA) specify that clinical training needs are to be prioritized over service delivery needs (American Psychological Association [APA], 2015). This trainee-centered view is reinforced by the profession's ethical standards, which include students among the groups who may be considered vulnerable, meriting safeguards and protections (APA, 2017). However, institutional administrators may not always recognize or accept the profession's prioritization of training over the needs of the institution, or may not view trainees as meriting special protections.

Trainees' differential and sometimes ambiguous status as students or essential employees was particularly relevant for interns, who may be simultaneously students and employees. The situation may be complicated further in medical settings, where psychology interns are typically considered comparable to medical residents in clinical competence and training level, though medical residents have both their terminal degree and license while psychology interns have neither. During the pandemic, medical residents and fellows were routinely expected to fulfill their obligation as licensed medical professionals to deliver care regardless of potential exposure or reasonable fear of risk. Medical students, however, were afforded protections based on Association of American Medical Colleges (AAMC) national guidance (e.g., suspended clinical rotations, discontinued direct patient care activities; AAMC, 2020). At many sites, psychology trainees were treated, requested to be treated, or were advocated for as warranting protection and relief from in-person patient care responsibilities, similar to medical students. While this

approach may have aligned with interns' student status, it may have appeared inconsistent with their perceived equivalence to medical residents and thus may have engendered resentment or concern about interns' commitment to patient care. When institutions did not exempt students from essential employee status, requests to remove interns from in-person care may have been interpreted as suggesting psychology as a discipline (versus students specifically) no longer be considered essential. In medical settings, where HSP has worked hard to be perceived as equivalent in value to other healthcare professions, treating HSP trainees differently from other essential healthcare trainees raised concerns of potentially troubling and far-reaching negative implications for the discipline's status as a healthcare profession.

Maintaining Program Integrity. Regardless of sites' local institutional and governmental constraints, maintaining the integrity of the training experience was challenging for virtually every program. Under normal circumstances, the HSP education and training trajectory is a carefully planned and intentionally delivered developmental sequence designed to culminate in the doctoral degree and attainment of the requisite knowledge, skills, and competencies for entry to HSP practice by the end of internship, and advanced or specialty practice by the end of postdoctoral training (APA, 2015). For many sites, this training trajectory faced substantial disruption. Didactics were moved online, research progress was often slowed or halted by the need to suspend in-person data collection, and the quantity of training hours or proportion of time spent in clinical experiences were suddenly reduced. Even when clinical training continued, trainees and supervisors worried about the quality of training if supervision and service delivery methods changed drastically, trainees and supervisors were learning these new modalities simultaneously (e.g., telehealth), or trainees and supervisors were stressed or

distracted by the pandemic and its effects. The transition to remote delivery of didactic instruction, clinical services, and supervision also highlighted access disparities among trainees. Not all state licensing boards relaxed policies (e.g., on HIPAA, interstate practice) to align with federal policies removing barriers to care, limiting some trainees' ability to continue their clinical training (Association of State and Provincial Boards of Psychology [ASPPB], 2020).

Utilizing Telehealth and Telesupervision in Training. With the transition to telehealth and telesupervision, questions arose regarding how and whether to count clinical services delivered via telephone or video on internship or licensure applications. With institutional closures and stay-at-home orders, many training sites began to deliver supervision primarily or completely via remote methods (i.e., telesupervision), which did not align with telesupervision maximums articulated by accreditation standards (e.g., APA, 2015) or with many state licensing regulations (ASPPB, 2020). Supervisors' use of direct observation as a routine part of their training or as required for accreditation often became more difficult, raising questions about how programs were able to ensure training quality and trainee competency. Technological solutions were not equally accessible for all trainees, such as those with socioeconomic or geographic limitations to stable internet or for whom technology could not accommodate their specific disability. This resource differential also occurred across programs, with some programs having ready access to technological solutions and others unable to access or afford them.

Managing Trainee Distress. Throughout the pandemic, rapid changes taking place in most institutions and the lack of knowledge about how the pandemic would unfold created considerable uncertainty and anxiety for many trainees, faculty and staff. Students questioned how a reduction in hours would impact their internship applications, interns wondered what

would happen if they were unable to complete the internship and doctoral degree on schedule, and postdoctoral residents worried about the impact on licensure and employment. Program and training directors struggled with how to meet training standards in the context of making significant and potentially abrupt and unexpected modifications to training while balancing trainee needs, clinical service delivery, and institutional and regulatory constraints.

Many trainees experienced anxiety about personal health and safety, particularly if expected to continue to present in-person or deliver face-to-face services. Trainees expected to continue on-site work at times described feeling forced to do so despite significant worry about their well-being or frustration at not sufficiently contributing to the physical distancing deemed necessary to “flatten the curve” of virus spread. Concerns about direct patient contact (at times with insufficient or no PPE), use of public transportation, and how personal illness or quarantine would be managed were reasonably frequent. As training leadership navigated quickly evolving circumstances and increased work demands, trainee frustrations about confusing, inconsistent or delayed communication were not uncommon, potentially compounded by trainees not being privy to decision-making processes and complexities. Challenges managing trainee distress in the context of institutional constraints and inherent uncertainty about risk were a common experience among training programs.

Addressing Discrepancies Across Settings and Stakeholders. The COVID-19 pandemic highlighted both the importance and limitations of the collaborations necessary to ensure successful HSP education and training. While academic programs and training sites collaborate to advance and support trainees’ competency attainment, they each bear different responsibilities and foci, as well as varying interpretations of their roles in the HSP education and training partnership. Institutional/agency policies, degrees of consideration of education and training

values, and interpretation of policies governing HSP training all played a role in programs' and training sites' responses to the COVID-19 pandemic. Differential and sometimes conflicting or seemingly arbitrary responses across programs and agencies (e.g., proceeding with vs. discontinuing patient care, allowing or disallowing work from home, implementation and timing of telehealth or lack thereof, variable utilization of physical distancing and screening measures, offering vs. conserving PPE), particularly in the context of widespread communications from varying geographic regions and stages of virus impact (e.g., via listservs, blogs) often added to the sense of chaos, unfairness, or desperation experienced by many trainees and programs.

Education and Training Organization Responses

Recognizing the escalating challenges and concerns as the public health crisis progressed, HSP education and training leaders and influential stakeholders began working together to develop guidance to inform decisions about HSP training and trainee service delivery during COVID-19. On March 20, 2020, four organizations charged with oversight of accreditation, implementation of internship and postdoctoral training, and licensure regulation – Association of Psychology Postdoctoral and Internship Centers (APPIC), the American Psychological Association (APA), the Canadian Psychological Association (CPA), and the Association of State and Provincial Psychology Boards (ASPPB) – issued a joint statement addressing training community concerns (Baker, et al. 2020). APPIC, APA, CPA, and ASPPB recognized that variation across their respective purviews challenged training programs' ability to swiftly identify and modify programs while minimizing undesirable consequences. For example, though a given training modification (e.g., reduced direct service hours, telehealth, telesupervision) might be acceptable to one entity it might not be so for another, with potential consequences for both training programs and their students. With this joint statement, the four organizations

expressed their intent to communicate actively and, to the extent possible, coordinate each organizations' responses to potentially needed modifications to education and training during the pandemic. The joint statement acknowledged some specific anticipated challenges to training, including the potential for COVID-19 to disrupt some trainees' ability to attain the competencies required to meet training and licensure requirements, and that specific impacts would vary across programs and jurisdictions. The statement also acknowledged that individual programs were in the best position to evaluate trainee competence and encouraged program flexibility in determining how competencies are attained and evaluated (Baker et al., 2020).

Despite the importance of this early call for flexibility, the training community needed more specific guidance. Two education and training organizations – the Council of Chairs of Training Councils (CCTC) and APPIC – were well-positioned to provide such guidance. CCTC serves as an umbrella organization for 15 training councils that represent nearly 1800 programs, training clinics, and institutions responsible for doctoral, internship, and postdoctoral HSP training across the United States and Canada (<https://www.cctcpsychology.org/about/>). CCTC shares, formulates, and advocates for policies and practices that improve HSP education and training. APPIC encompasses over 1000 internship and postdoctoral programs in the United States and Canada (<https://www.appic.org/>); member programs meet specific criteria intended to affirm sufficiency of program quality (e.g., quantity of supervision, breadth of training experiences, minimum number of hours, etc.). APPIC plays a significant role in organizing HSP internship and postdoctoral selection, setting standards for training, and offering consultation for those encountering challenges in training (i.e., Informal Problem Consultation service).

With breadth of representation and depth of experience with COVID-19-related training challenges, CCTC and APPIC each provided guidance to the education and training community

intended to support principled decision-making in adjusting training policies, procedures, and practices in response to the rapidly evolving situation, with the health and safety of all stakeholders in mind. The statements had three goals: 1) to address the multiple concerns of trainees, programs, and clinical sites in ways that could increase consistency in decision-making across sites, while recognizing that some site-specific differences may be necessary and desirable; 2) to provide guidance for how to balance professional values, training standards and regulations, and institutional policies in decision-making; and 3) to provide specific recommendations for training expectations and supports during the pandemic that all doctoral, internship, and postdoctoral programs were urged to consider.

CCTC Response

During and immediately following its Spring 2020 meeting (March 19, 2020 teleconference), CCTC member representatives and liaisons engaged in extensive discussion and review of the challenges facing educators, training programs, and trainees as the COVID-19 pandemic impacted training opportunities and responsibilities. Collectively, the council developed specific guidance and recommendations for decision-makers in HSP education and training. The resulting statement was disseminated to training councils and other HSP education and training stakeholders on March 23, 2020 (CCTC, 2020).

In developing its statement, the CCTC attended to the need to balance requirements for accreditation and licensure with supporting students and trainees during this uncertain time. The health and safety of all stakeholders (i.e., students, trainees, supervisors, patients/clients, training program faculty) was considered at all levels of training and in diverse training contexts. The statement explicitly acknowledged that training programs cannot rely solely on usual practices. The CCTC encouraged decision-makers to use best practices as a starting point in making

necessary adjustments to accomplish HSP education and training, protect trainee emotional and physical health, and facilitate patient/client care, student education, research, and other tasks that are typically part of HSP trainees' responsibilities. The principles and recommendations articulated in the CCTC statement were intended to be applicable across a changing landscape, as new challenges emerged and varied contexts required specific implementation differences.

Guiding Principles. Table 1 summarizes the CCTC statement's four guiding principles for decision-making that acknowledge the rapidly evolving nature of the pandemic and the need to be nimble while maintaining the integrity of HSP training. These key principles encouraged balance (an underpinning of all recommendations) in considering all relevant issues, weighing the risks and benefits of decisions to trainees, as well as their patients/clients, students, and others. In addition, the principles of a developmentally-sensitive trainee focus and flexibility underscored virtually every recommendation for training during the pandemic. Consistent with the SoA (APA, 2015), decision-makers were urged to prioritize the needs of trainees, including the need to gain training experiences, develop competencies, maintain health and well-being, and make adequate progress toward degree completion and career entry. Training programs and sites were urged to seek alternative ways to meet trainee, patient/client, student, and training site needs, as well as program requirements. Finally, the statement emphasized the importance of using a social justice lens that acknowledged, for example, the power differential that may make it difficult for trainees to advocate for their needs. The CCTC encouraged stakeholders to use this lens when making decisions that may assume trainee resources (e.g., financial, material, or personal) or about which trainees may feel unable to express concern.

Recommendations. The six specific CCTC recommendations listed in Table 1 used the principles as a foundation from which to offer guidance for addressing the most presently

pressing issues related to HSP education and training during the COVID-19 pandemic. Some of the CCTC recommendations targeted multiple stakeholders in training and education, including academic programs, clinical training programs and sites, and accreditation and regulation bodies, while other recommendations targeted specific stakeholder groups.

The recommendation to adjust training requirements likely impacted by COVID-19 targeted accreditors and licensing boards specifically. Training programs may be unable to meet specific requirements during the pandemic (e.g., ensuring direct observation at each practicum site; providing at least 50% of supervision in person). Knowing that regulatory bodies are working together to maintain focus on key aspects of trainee competency development while being flexible enough to allow temporary pandemic-related deviations from requirements could allay many program and trainee anxieties.

Most of the other recommendations were directed to training program faculty and staff, as well as to program and institutional administrators. For example, in some settings a decision to limit in-person contact may be made by a program director, whereas other settings require action from human resources departments. Many actions to minimize critical resource disparities can be taken at the program or individual mentor/supervisor level, such as providing training in telehealth, helping trainees problem-solve to find private space, or allowing trainees to conduct therapy sessions via telephone for patients/clients without video access. Other actions may need institutional or community resources, including helping trainees secure access to a laptop, online platforms, or free or low-cost internet. Following the recommendation to minimize the impact of the pandemic on trainees' finances and program completion will likely require coordination between the program and their institution; although specific requirements may be set by a training program, degree requirements are often set by the university and budgets are typically

controlled by the department or institution. Programs and their higher administrations will need to communicate about how to flex while still enabling trainees to meet institutional requirements, as well as about any budget implications of protecting trainee pay during the pandemic.

The recommendation to pursue access to training that goes beyond didactic distance education targeted training programs and institutions, as well as the private sector that manages instructional materials. For example, training programs were encouraged to use the literature on disability accommodations to guide alternatives to traditional in-person or distance education approaches (e.g., web-based systems for data collection, test administration, and scoring). Test publishers and online platform companies were urged to make web-based resources available to training sites at reduced or no cost.

The final recommendation, to communicate and consult with one another, was a call to engagement of the entire body of stakeholders in HSP education and training. As the COVID-19 pandemic has reminded all of us, consultation is an important competency throughout our careers, especially during a novel and fast-moving situation.

APPIC Responses

As the pandemic spread, the APPIC Central Office received many questions, concerns, and requests for consultation and guidance from trainees, training directors, and directors of clinical training of graduate programs who were concerned about the impact of COVID-19 on training. To respond to training community needs in the face of disruptions and anxieties provoked by the pandemic, the APPIC Board of Directors disseminated three statements between March 21st and April 7th. These statements reflected the APPIC Board's wish to issue timely, practical recommendations that could be commonly applied, while also recognizing the variability across programs and situations, as well as uncertainty about the relevance and

feasibility of specific recommendations in the context of other regulatory constraints and developments during the pandemic. In addition, the Board wished to maximize prioritization of trainee health and safety, while not wanting to be globally prescriptive when many programs were managing the situation well and to the satisfaction of all involved parties.

Statements & Actions. On March 21st, APPIC released its first independent statement about COVID-19 to the training community (APPIC, 2020a). APPIC acknowledged the diversity among its members and the differential impact related to COVID-19 (i.e., from total site closure to normal functioning), which prevented a singular set of specific recommendations.

Underscoring the importance of the physical and emotional wellbeing of staff and trainees, APPIC encouraged programs to develop training adaptations while remaining mindful of established regulations (e.g., APPIC membership criteria, accreditation standards, licensure requirements), and to maintain communication among students, DCTs, and training programs.

Around this time, APPIC also published COVID-19 related FAQs to address a range of questions and concerns commonly presented to APPIC Central Office (APPIC, 2020b). Topics included telehealth, potential off-site training activities, trainee distress and anxiety, and navigating challenges with institutional policies. APPIC enacted a policy change to allow hours spent delivering telephone services to be included by doctoral students on the standardized APPIC Application for Psychology Internship (AAPI) form and on behalf of CCTC, offered a central online repository of training resources for programs and students (APPIC, 2020c).

As programs and students continued to contact APPIC Central Office, it was apparent to the APPIC Board of Directors that there was a strong wish for explicit guidance or directives. In an effort to be responsive while maintaining awareness of the diversity of programs and COVID-19 impacts, the APPIC Board issued a second statement that articulated guiding principles and

current recommendations for those making decisions about psychology training (APPIC, 2020d).

With key components presented in Table 2, this statement included three principles that focused on differences between trainees and faculty/staff (i.e., power differential, resource differential, and disproportionate professional risk for trainees), with programs being strongly encouraged to consider whether those without the power and resources of faculty/staff should bear the same responsibilities and burdens as faculty and staff characterized as essential employees. APPIC also made eight recommendations for training programs, several of which were grounded in the most frequent concerns expressed by trainees, such as trainee distress about their health and safety (i.e., consideration of telehealth and work-from-home options, adherence to CDC guidelines) and concerns about position and resource security (i.e., preserving stipends, benefits, and leave), or reflected concepts or actions the APPIC Board wished to remind its member program to bear in mind (i.e., attending to APPIC membership criteria, prioritizing training over service delivery, maintaining the Match agreement, and consulting with APPIC as needed).

This APPIC statement noted geographic variation in degree of COVID-19 risk/impact, associated variation in the nature or timing of potential training modifications, and encouraged programs to consider guidance from relevant local and national authorities in determining modifications or protective actions. The statement also commented about frequent consultation requests from psychology interns in medical settings and acknowledged that fundamental differences in ethical standards between psychology and medicine, particularly concerning whether trainees should continue to deliver care despite personal risk, may give rise to conflict. In such cases, individuals were encouraged to maintain respect and to apply the APA Ethics Code standard for Conflicts between Ethics and Organizational Demands.

On April 7th, 2020, the APPIC Board of Directors and the APPIC Postdoctoral

Committee released guidance intended for all members of the postdoctoral training community (APPIC, 2020e). Whereas previous statements were more focused on present COVID-19 impacts and associated modifications, this statement also incorporated more forward-thinking guidance related to incoming postdoctoral residents scheduled to begin in the summer or fall of 2020. The statement suggested postdoctoral training directors and incoming residents communicate proactively to affirm plans and identify potential challenges, such as the potential need for delayed program start or overlapping cohorts. The statement offered a reminder that position agreements between incoming residents and programs are a professional commitment that should be upheld “barring extreme and rare circumstances,” while also acknowledging that such conditions may be met in the context of the pandemic. The statement also addressed current postdoctoral residents, noting the need for programs to consider residents’ goals, competencies, and program integrity while supporting the safety of residents, patients, and training staff, as well to support residents who may be experiencing disruptions in the job search or licensure process.

Common Themes Across Training Organization Statements

Several shared values and suggestions are evident in both the CCTC and APPIC statements. Both included a clear statement that prioritizes training and trainee well-being, while also balancing patient/client, institutional, and regulatory considerations. Both explicitly recognized that trainees may be affected by limited resources and power differentials that exist between trainees and their programs and training sites. Likewise, both CCTC and APPIC acknowledged that disruptions to training are highly impactful for trainees, with potential for a disproportionately negative impact on degree completion, financial stability, and career options, relative to post-degree professionals. Consequently, both organizations noted programs’ ethical obligation to protect trainees from potential negative impacts of COVID-19, within the context

of institutional policies and government health and safety orders and recommendations.

The CCTC and APPIC statements share several overlapping recommendations (e.g., considering telehealth and work-from-home options, minimizing disruptions to training progress, using consultation). Both groups recognized the complexity of the situation, carefully weighed potential pros and cons of their recommendations, and concluded that anticipated benefits (e.g., continued clinical care with enhanced trainee and patient/client safety) outweighed potential costs (e.g., difficulties implementing remote services and supervision, differentiation between pre-degree HSP trainees and other healthcare professionals). The full implications of these recommendations remain to be seen, and future research is needed to examine their impact.

Learning from COVID-19: Educational Evolution and Opportunities for Redesign

The challenges and creative solutions during the COVID-19 pandemic will likely yield lasting impacts on education and training, and also present important opportunities to consider further change that will persist past resolution of the current public health crisis. The pandemic required many constituencies within HSP to rapidly address challenges, engaging in activities that might otherwise not have been fully embraced or that might have taken months or years to consider, plan, and implement. The necessity of quick and substantial modifications may have functionally accelerated the evolution of HSP education and training, especially if adjustments initially implemented as temporary measures become more accepted or routine. Beyond the somewhat unintended benefit of incremental changes to HSP education, training, and practice that the pandemic has fast-tracked, the discipline's experiences during COVID-19 may represent a watershed moment for HSP, inviting consideration of more fundamental changes in the way the discipline views its own identity and implements HSP education and training.

Developing and Implementing Effective Distance Education. As a result of the

pandemic, many HSP educators received “crash courses” in how to teach and supervise using video conferencing and other online and remote learning technologies. Rather than simply returning to pre-pandemic training approaches once COVID-19 abates, HSP educators can use the adaptations and accommodations required by the pandemic as an opportunity to rethink usual training practices and consider more flexible and innovative ways to use distance education to facilitate trainees’ knowledge and competency development.

Widespread distance learning may have first been assumed to be a temporary stop gap measure while awaiting resolution of the acute public health crisis. However, anticipation of longer-term public health measures (e.g., prolonged physical distancing) likely renders distance learning a long-term necessity. Emerging evidence suggests that online instruction (one distance education method) can be an effective method of education for healthcare trainees (Bajpai, Semwal, Bajpai, Car, & Ho, 2019; Souza, Mattos, Stein, Rosario, & Magalhaes, 2018). For many HSP educators, the immediacy required to pivot to remote teaching methods during the COVID-19 pandemic may have led them to simply move lectures, discussions, or the same learning activities planned for in-person learning to an online format. As the disruption of the pandemic abates, it is incumbent upon HSP educators to align distance education methods to the existing evidence-base and best practices to optimize virtual learning modalities. In addition, expanding this evidence base through research evaluating distance education methods will be an important undertaking for psychology as a discipline, and one for which it is readily equipped.

Distance education also offers expanded opportunities for collaboration that may enrich the educational experience. Multi-site online learning collaboratives could provide an efficient way for trainees to attain discipline specific knowledge or receive specialized training not available at their home programs. Indeed, considering opportunities for engagement with

students in colleagues in other institutions, and even other countries, would expand access to diversity of thought and experience in ways previously unseen in HSP education and training.

Delivering Telesupervision. The physical distancing required by the pandemic may also accelerate developments in how supervision is delivered and how accrediting and licensing bodies address telesupervision. A small but growing body of research supports the utility of telesupervision (e.g., Inman, Soheilian, & Luu., 2019; Jordan & Shearer, 2019; Martin, Lizarondo, & Kumar., 2018; Wood Miller, & Hargrove, 2005), and experience with telesupervision during the COVID-19 pandemic will likely prompt important expansion of the evidence base examining its effective use. Further, development of effective, evidence-supported telesupervision methods could greatly increase trainees' and supervisors' access to one another even when they are not physically proximal, whether they are simply across a large medical complex or across a large rural state. Telecommunication options used during the pandemic have enabled supervisors to observe and join sessions delivered via video conference, which offers greater opportunities for supervisors to extend their direct observation of trainees and to provide modeling or in-vivo guidance during health service delivery. Where telesupervision may offer enhanced supervisory experiences, HSP educators must consider embracing it as a viable supervision method, even when it is no longer a necessity.

With respect to potential regulatory changes and telesupervision, the pandemic has already resulted in some states changing their interpretation of "face-to-face" supervision requirements to include video teleconferencing (ASPPB, 2020). Although in-person supervision will likely retain an important role in HSP training, the broad use of telesupervision during the pandemic may prompt accreditors and regulatory bodies to re-examine their policies on telesupervision under more routine conditions. Formal evaluation of the outcomes of such

supervision practices and the conditions under which telesupervision may be effective would provide important guidance for potential policy changes.

Expanding Clinical Service Delivery Opportunities. Clinical services delivery may be forever changed by COVID-19, as the healthcare community and those it serves more fully realize the potential of telehealth in expanding healthcare access (e.g., for rural or other historically underserved populations, individuals reticent about possible stigma of visiting a mental health setting), its functional efficiencies (e.g., shared office space, reduced scheduling burden and travel time, decreased no-show rates), and potential clinical benefits (e.g., ability to observe clients or patients in their natural environment). Although some training programs had already included training in telepsychology in their curricula, HSP trainees' instruction in this area has generally been limited (Barnett, 2018; McCord, 2015). Permanent inclusion of telepsychology training, and explicit education and supervision in effective delivery of telehealth as a competency, are important and necessary expansions to training programs. Expanding the small research base on telepsychology training (e.g., Simpson, Guerrini, & Rochford, 2015) is also critical, as is elucidating clinical circumstances that may render telepsychology inadvisable.

The relevance and success of ongoing incorporation of telepsychology services into training depends, in part, on changes in the regulation of clinical service delivery. The pandemic highlighted how state-specific licensing laws can create barriers to continuity of care for patients/clients who live across a state line, travel, relocate temporarily to another state, or have clinicians (or supervisors) who travel or relocate. ASPPB's PSYPACT interstate compact (<https://www.asppb.net/page/PSYPACT>) is an important step toward national credentialing, as once enacted, it will allow licensed psychologists to provide telepsychology or temporary in-person services across state lines. However, adoption and implementation has been slow;

although 12 states have adopted PSYPACT legislation since 2016 and an additional 17 states have legislation pending, procedures to grant authority to practice have yet to be developed. HSP educators can play a critical role in accelerating progress toward interjurisdictional practice by working with state licensing boards and legislators to promote implementation of the compact.

Adopting More Robust Competency Evaluation. The pandemic highlighted the benefit of re-evaluating many of the longstanding standards, policies and regulations about how HSP evaluates trainee competencies. The profession has long relied on clinical hours as a proxy for clinical competence, with a minimum number of clinical hours required by many internship sites and codified in state licensing acts as a condition for independent practice. These practices persist despite a lack of compelling evidence to support the validity of such minimums and ongoing calls to evaluate competencies more directly (e.g., Fouad et al., 2009). Currently, competency is most commonly evaluated through locally adapted rating measures with poor or unknown psychometric properties (Callahan & Watkins, 2018). However, research and resources are emerging to support standardized and validated competency ratings (e.g., Price, Callahan, & Cox, 2017) and performance-based competency evaluations (e.g., Ingram, Cribbet, & Schmidt, 2019; Meghani & Ferm, 2019). Given that many trainees will accrue fewer clinical hours during the pandemic, the impetus to more fully adopt direct competency assessment is more pressing than ever, and has the potential to produce long-lasting benefit to HSP.

Modifying Admissions and Selection Practices. Changes necessitated by the pandemic provide an opportunity to reconsider longstanding admissions/selection practices to address concerns of access and equity. Increased comfort with video conferencing may encourage doctoral programs, internships, and postdoctoral programs to consider relaxing the convention or requirement for in-person applicant interviews. Despite survey data suggesting that students

prefer in-person over other types of internship interviews (APPIC, 2016), in-person interviews and the accompanying travel are difficult to justify given their questionable validity (e.g., Kreiter & Axelson, 2013) and potential to limit equity across students with diverse personal characteristics and financial resources (e.g., Burmeister et al., 2013; Lowrey, Jutunen, & Duan, 2009). Prior to the pandemic some programs had already moved from in-person to telephone or video interviewing, due to their remote location or as part of a social justice mission. The potential for continued pandemic-related travel restrictions, physical distancing requirements in training settings, and increased economic hardships may prohibit in-person graduate, internship, and postdoctoral interviews for one or more selection cycles, offering the opportunity for adoption and evaluation of more feasible and equitable admission and selection processes.

Similarly, with GRE test centers closed during the pandemic and potentially affecting admissions for the upcoming year, the pandemic may also prompt more widespread reconsideration of the role of the GRE in doctoral program admissions. Use of the GRE in graduate admissions has been increasingly questioned due to concerns with access restrictions for diverse applicants (Callahan et al., 2018; Roberts & Ostreko, 2018); doctoral programs may now be prompted to more fully embrace admissions processes that do not rely on GRE scores (Roberts & Ostreko, 2018). Although these sorts of holistic admissions were already gaining traction in psychology, the pandemic provides yet another reason to reconsider potential barriers to recruiting a more diverse HSP workforce.

Reconsidering Internship and Degree Timing. Although not a novel consideration (Boggs & Douce, 2000), reversing the sequence of the internship and conferral of the doctoral degree is an idea the profession may be wise to reconsider. The pandemic highlighted challenges created by psychology interns' status as doctoral students enrolled in one academic institution

while being trainees and clinical employees at another institution, and revealed potential advantages of moving the internship post-degree. Placing the internship after the doctoral degree would grant doctoral programs clearer and more complete jurisdiction over clinical training of their students and likewise grant internship training programs clearer and more complete jurisdiction over their interns' training.

Complexities that arose in considering differential protections for psychology interns versus medical residents during the pandemic also suggest that the timing of licensure may also need to be addressed. The currently endorsed model licensing law (APA, 2010) adopted by many jurisdictions allows trainees to apply for licensure without postdoctoral training, but assumes substantial training at the practicum and internship levels prior to degree conferral. If the internship were moved to post-degree (meaning that it would then become postdoctoral training), it is likely that jurisdictions that do not require postdoctoral training would need to rewrite their laws to recapture the required internship training that currently takes place prior to degree completion. Clearly, rethinking the sequence to degree introduces complex issues that extend well beyond the scope of this paper, but ones that merit reexamination.

Re-examining Psychology's Values and Identity as a Health Service Profession.

Another potential lesson from the pandemic is that not all HSP professionals agree about the role of HSP trainees in the broader healthcare system. As such, HSP may need to rethink its responsibilities as part of the healthcare community. Although the practical and ethical argument that unlicensed, pre-degree trainees should be protected has merit, it is notable that other health professions did not always distinguish between their pre-degree trainees and post-degree professionals. In medicine and nursing, trainees who were close to training completion were at times hastened to independent provider-level duties to meet health care workforce needs

(Murphy, 2020). Similarly, whereas the APA Ethics Code is silent on any obligation of psychologists to provide care despite personal risk, the American Medical Association code of ethics indicates “the obligation to ‘provide urgent medical care during disasters,’... ‘even in the face of greater than usual risk to physicians' own safety, health or life.’” (AMA, 2020). Indeed, physicians’ duty to treat in the face of personal risk, including during epidemics or pandemics, long predates COVID-19 (Huber & Wynia, 2004; Hughes & Marcozzi, 2004; Wynia, 2007). Considering these fundamental differences in values (i.e., imperative to press in despite personal risk vs. principle to minimize and protect from risk) and HSP’s role as a healthcare profession is a critical conversation, particularly related to psychologists serving in medical settings.

Further, thoughtful examination of the merits and challenges of considering psychologists and psychology trainees as essential personnel in healthcare settings is warranted. It is likely that opinions differ on the appropriateness of conceptualizing psychology or psychology trainees in this way, and developing a shared understanding of expectations across settings would inform and codify psychology’s identity as a health service profession, allow clear communication of expectations to prospective trainees, and pave the way for appropriate preparation for the duties of essential personnel as part of HSP training. Importantly, it may help avoid the problems inherent in defining oneself as an essential part of the healthcare community when it engenders personal benefit but not when it confers risk.

Reconstructing HSP Education and Training. Since the 1980’s there have been calls for a Flexner-type examination of the education and training leading to the professional practice of psychology (Rozenky, 2013). This sort of comprehensive and authoritative examination would consider all aspects of the educational landscape (e.g., admissions common language, core curriculum, needed competencies, workforce entry, regulatory oversight) in the interest of

reconstructing the entire system, if necessary, to ensure high-quality, relevant education of psychological healthcare professionals. Many stakeholders have argued that this sort of sweeping evaluation and overhaul is unnecessary and that psychology can meet the same goal with a more incremental approach to change. Indeed, over the last several decades, the discipline made many advances that, as a gestalt, form “a robust, proto-, de facto Flexner-like approach” (Rozenky, 2013, p. 709). Some of the opportunities described in the current paper could push these advances further, fostering continued evolution of educational practices and workforce preparation. Other efforts currently underway, such as accreditation of master’s-level psychology education and training (Grus, 2019), are also bringing notable change to the profession. At the same time, the challenges and necessary changes highlighted by the COVID-19 pandemic may present an opportune time to consider a comprehensive evaluation and potential reconstruction of HSP education and training. A Flexner-type Commission could provide a forum for the discipline’s stakeholders to weave together the many advances, both accomplished and planned, and to identify weaknesses, limitations, or opportunities not yet realized. With a radical willingness to “put everything on the table” and critically examine the gestalt of HSP education and training, such an effort could ensure that HSP educational system is meeting the profession’s goal to prepares HSP scientists and practitioners to efficiently and effectively address society’s mental health needs, not just of the present but of the future.

Conclusions

The COVID-19 pandemic has been an unprecedented world event bringing much disruption and distress, including among the psychology training community. Conditions of great uncertainty and rapidly evolving circumstances, along with numerous challenges specific to HSP education and training, necessitated complex decisions and swift training/educational

adjustments. Established leadership organizations in HSP education and training offered principled guidance and recommendations to inform responses to these challenges.

What was unquestionably an unwelcome and incredibly challenging occurrence, the COVID-19 pandemic also brings the opportunity to advance and even transform HSP education and training. The discipline can choose to embrace and extend the benefits of incremental change hastened by necessity, and to capitalize upon the opportunity to critically examine and redesign long-standing education and training practices. Taken together, the challenges and responses resulting from the pandemic offer six key opportunities for HSP education and training, including to: 1) examine, extend and build the evidence base for innovative educational modalities, particularly those delivered via distance learning technology, 2) re-examine the rationale and evidence base for longstanding admission, selection, and training practices, 3) advance development of competency evaluation methods to robustly measure established profession-wide and novel competencies, 4) reconsider the relative timing of internship and doctoral degree, 5) re-evaluate the place of psychology and its trainees alongside other health service professions, and 6) consider a comprehensive, Flexner-type examination of what is needed to ensure that HSP education and training is preparing its graduates to meet the psychological healthcare needs of the future. Notably, many of the opportunities presented here are not new; some have been considered within HSP for years or even decades. What may be new is the HSP training community's increased motivation to change, based on the incredible need created by the pandemic, supported by a growing evidence base, and facilitated by technological advances. In capitalizing on this motivation and momentum, HSP should continue to explore opportunities for innovative improvement.

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TABLE 1: Key Elements of Council of Chairs of Training Councils (CCTC) Statement on Education and Training Considerations During COVID-19 Pandemic (CCTC, March 23, 2020)
Principles Guiding Decisions Regarding Trainee Requirements and Responsibilities

<u>Principle</u>	<u>Description</u>
Balance	Decision-makers should weigh relative risks and benefits of decisions to trainees, patients/clients, and others, based decisions on ethical standards, and place high priority on health and safety of trainees and individuals they serve.
Developmentally-Sensitive Trainee Focus	Decision-makers should prioritize trainee needs (e.g., to gain training experiences, develop competencies, maintain health and well-being, make progress toward degree completion and career entry), seek alternative ways to meet these needs, and consider trainees in the context of their developmental level in decisions regarding trainee expectations and responsibilities.
Flexibility and Creativity in Developing Trainee Competency and Meeting Responsibilities	Decision-makers should consider novel methods of instruction, clinical care, research, etc that may be necessary during COVID-19, even when these methods may be less established or fall short of ideal practices.
Social Responsiveness	Decision-makers should recognize the power differential

that may impact trainees' ability to self-advocate;
individuals with power and responsibility over training must
protect trainee needs.

Specific Recommendations

1. Limit In-Person Contact
2. Adjust Educational and Licensing Requirements
3. Minimize Adverse Impact on Trainee Finances and Program Completion
4. Pursue Access to Training Beyond Distance Education
5. Minimize Critical Resource Disparities
6. Use Consultation to Address Challenges

TABLE 2: Key Elements of Association of Psychology Postdoctoral and Internship Centers

(APPIC) Statement on COVID-19 (Statement #2, March 31, 2020)

Principles to Consider in Decision-Making About Potential Training Modifications

<u>Principle</u>	<u>Description</u>
Inherent power differential for trainees	Trainees may reasonably feel less able to advocate for themselves or make decisions in line with their interests.
Resource differential for trainees	Trainees often have fewer financial resources than faculty/staff and thus fewer choices available (e.g., fewer financial reserves, smaller allotments of paid/sick leave, lesser healthcare benefits, etc.).
Disproportionate professional risk for trainees	Relative to faculty/staff, trainees have potential to incur greater career risk and/or experience negative consequences for electing not to adhere to institutional policies and/or expressing concern about them.

Current Recommendations

1. Employ/Prepare for the use of telehealth immediately
2. Consider work-from-home options immediately
3. Adhere to CDC guidelines
4. Attend to APPIC membership criteria

5. Prioritize training over service delivery
6. Preserve and protect trainee stipends, benefits, and paid leave time
7. Maintain the Match agreement
8. Consult with APPIC regarding problem situations and concerns