

2021-2022 PRE-DOCTORAL RESIDENCY IN PSYCHOLOGY

MENTAL HEALTH AND ADDICTIONS

NOVA SCOTIA HEALTH - ANNAPOLIS VALLEY

	2
1. ABOUT ANNAPOLIS VALLEY	3
2. ABOUT NOVA SCOTIA HEALTH AUTHORITY	4
2.1 PSYCHOLOGICAL SERVICES AND THE DISCIPLINE OF PSYCHOLOGY	4
2.2. Supervising Psychologists	5
3. PRE-DOCTORAL RESIDENCY IN PSYCHOLOGY	7
3.1 PURPOSE	7
3.2 STRUCTURE	7
4. PRIMARY TRACKS AND ROTATIONS	8
4.1. Adult Mental Health Track	8
4.2. Child and Youth Mental Health Track	12
5. SUPERVISION	15
5.1. Standards for Supervision	15
6. EVALUATION	16
7. EMPLOYMENT AND WORK LOAD PROCEDURES	17
7.1. HOSPITAL/CLINIC POLICY	17
7.2. STIPEND AND BENEFITS	17
7.3. OVERTIME POLICY	17
7.4. RESOURCES	17
8. APPLICATION PROCEDURE	18

1. ABOUT ANNAPOLIS VALLEY

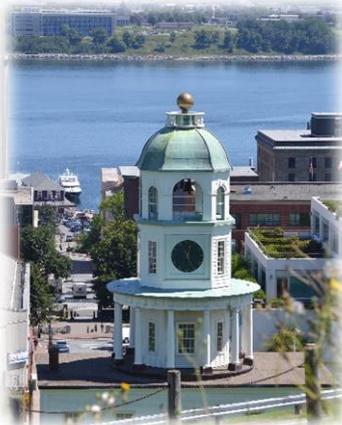
The scenic Annapolis Valley is located within the western peninsula of Nova Scotia and spans approximately 130 km from the picturesque town of Wolfville (home of Acadia University) to the historical and seaside towns of Annapolis Royal and Digby. The pre-doctoral residency program is primarily located in the town of Kentville, a 10-minute drive from Wolfville.



Within and around the towns of Wolfville and Kentville can be found a

variety of cultural, sporting and recreational activities including professional and community theatre, music, cinema, university sports teams, downhill skiing, golf, and fine and casual dining. Local farms and markets provide exceptional fresh food and quaint seasonal activities (e.g., apple picking, pumpkin patches, corn mazes), while the

growing winery, cidery, and microbrewery scenes provide many tasting options for connoisseurs of such adult beverages. Those who enjoy the outdoors will find much to appreciate in local provincial parks (Blomidon), hiking trails (Cape Split), and walking/running/cycling trails including our rails-to-trails system (an old rail-line that was converted into trails spanning the length of the valley). Annapolis Valley is also home to the Bay of Fundy, where you will find the highest tides in the world as well as opportunities for whale watching.



Within a leisurely hour's drive of Kentville is Halifax, Atlantic Canada's largest city and the capital of Nova Scotia. Within the city of Halifax, you will find historical attractions such as the

Halifax Citadel and Historic Properties on the Halifax Harbour. Halifax is also home to fine dining, shopping, theatres, museums, and an exciting night life. Also lending itself to a day-trip is Nova Scotia's south shore where you will find white sand beaches, the UNESCO Seaside Heritage town of Lunenburg, Peggy's Cove (home to one of the most photographed lighthouses in the world), and the home of the Oak Island Treasure Hunt.



Those looking for a weekend getaway will find a great destination in Cape Breton Island, home of the world famous Cabot Trail and the historical Fortress of Louisbourg. Aptly named "Canada's Ocean Playground", anyone with an adventurous soul will find lots to see and do during their residency year in Nova Scotia.

For more information on the Annapolis Valley and surrounding areas, please visit <https://novascotia.com/annapolisvalley>.

2. ABOUT NOVA SCOTIA HEALTH AUTHORITY

In 2015, nine distinct health-care districts amalgamated to become the Nova Scotia Health Authority (NSHA). NSHA is responsible for the publically-funded health-care of all Nova Scotians and is divided into four zones (Eastern [Cape Breton], Northern [Truro, Amherst area], Central [Halifax area] and Western [Annapolis Valley, Yarmouth, South Shore].

Our service is responsible for serving the Annapolis Valley area of the western zone and provides care to two counties (Kings and Annapolis). The majority of general health care within the area is delivered from Valley Regional Hospital (VRH), Soldiers Memorial Hospital (SMH), as well as several community health centres. Our health service is responsible for the care of a total referral population of approximately 100,000 people living in the region (www.avdha.nshealth.ca). VRH is located in Kentville, whereas SMH is located in Middleton, a 30-minute drive west of Kentville.



The majority of outpatient mental health services are offered out of the Chipman building (located 7KM from VRH in Kentville) and SMH (Middleton), with three satellite clinics (Wolfville, Berwick, and Annapolis Royal) offering some service. Services for both adult and child and youth are offered in these facilities. Adult psychiatric inpatient services and health psychology services are located in VRH. All services are within one hour's drive of each other with most services being considerably closer.

Service within outpatient mental health is delivered via the Choice and Partnership Approach (CAPA; Ann York & Steve Kingsbury, www.capa.co.uk), a service delivery model that attempts to balance client engagement with system capacity. Within this model, clients attend "Choice" appointments that serve as triaging and goal-setting appointments aimed at treatment-matching the client with the most appropriate stream of care in the most efficient manner. Residents learn about CAPA at the start of the year and are given the opportunity to work within the model. That said, training of Residents takes precedence over strict adherence to this model and flexibility is granted to ensure that Residents are able to develop competency in all areas of psychological service.

2.1 Psychological Services and the Discipline of Psychology

Psychological services are provided within the context of multidisciplinary teams (e.g., nursing, psychiatry, social work, clinical therapists, addiction counsellors) located within the primary mental health clinics in the two main facilities. Teams are also located within specific service units (e.g., psychiatric inpatient unit; medical unit). Staff psychologists are administratively responsible to mental health management at Nova Scotia Health, Annapolis Valley.

Currently, the Discipline of Psychology is made up of eight doctoral level psychologists (seven registered and one candidate register) and three Masters level psychologists working in the settings listed above. Doctoral level Psychologists supervise Residents. Psychologists meet on a regular basis to discuss issues relevant to Psychology. The Psychology Professional Practice Leader (PPPL) chairs and coordinates the meetings. There is a separate Residency committee comprised of the Director of Training (DoT), the PPPL and a representative each from adult and child and youth programs available to supervise Residents as well psychology resident.

2.2. Supervising Psychologists

Jeff Bailey, Ph.D., University of New Brunswick, 2015. Provincial Centre for Training, Education, & Learning; Adult Mental Health.

Currently serving as an Advanced Practice Lead providing provincial training and supervision. Clinical areas include assessment and treatment of adults with a variety of presenting complaints with a focus on anxiety and mood disorders, Post-traumatic Stress Disorder, Obsessive Compulsive Disorder, and Borderline Personality Disorder. Integrative approach to treatment with emphasis placed on cognitive-behavioural, dialectical-behavioural, and acceptance-commitment modalities.

Glen Berry, Ph.D. (Professional Practice Leader), University of Western Ontario, 1996. Adult Mental Health. Inpatient and outpatient adult clinical psychology; cognitive-behavioural and interpersonal approaches; special interest in anxiety, early psychosis, cognition and emotion; psychometric assessment including Rorschach and objective testing.

Alison Edgar Bertoia, Psy.D., Baylor University, 1996. Adult and Adolescent Mental Health, Registered (NS and Ontario) in Clinical, Counselling and Rehabilitative Psychology.

Assessment and treatment of clients with complex presentations including personality disorders, eating disorders, body dysmorphia, somatic concerns, using cognitive and dynamically-informed formulations and cognitive, dialectical-behavioral and interpersonal treatment orientations.

Terri Lee Cordwell, Ph.D., University of Saskatchewan, 2017. Child and Youth Mental Health.

Child and Youth clinical psychology; diagnostic, behavioral, intellectual, and learning assessments with children and youth (4-16 years of age). Cognitive Behavioural (CBT), Interpersonal, and Parent-Child Interaction Models. Treatment of range of presenting concerns including anxiety, Obsessive Compulsive Disorder (OCD), Adjustment Disorder, grief, attachment concerns, suicidal ideation, and trauma.

Omeed Ghandehari, Ph.D., University of Regina, 2018. Adult Mental Health.

Comprehensive assessment for differential diagnosis, treatment planning, and consultation to team members. Psychological treatment of adults presenting with a variety of concerns including anxiety and mood disorders, PTSD, personality disorders, and health psychology concerns (i.e., chronic pain). Facilitation of evidence-based intervention groups. Supervision of students and trainees.

Julie Longard, Ph.D., Dalhousie University, 2018. Child and Youth Mental Health.

Outpatient child and youth clinical psychology; assessment and treatment of clients with various presenting concerns including anxiety, low mood, and behavior difficulties; special interest in Autism Spectrum Disorders and Obsessive Compulsive Disorder; integrative treatment approach focusing on cognitive-behavioural, dialectical-behavioural, and acceptance-commitment modalities.

Victoria Pitura, Ph.D., Candidate Register, Lakehead University, 2019. Adult Mental Health.

Ms. Pitura is expected to be fully registered with NSBEP by January 2021.

Assessment and treatment of adults with various concerns including anxiety and mood disorders, personality disorders, and severe mental illness. Emphasis on cognitive behavioural approaches to treatment (i.e., CBT, ACT, and DBT).

Colin Pottie, Ph.D., Virginia Commonwealth University, 2008. Adult Mental Health.

Works primarily as a health psychologist (generalist) and is a member of several inpatient and outpatient multidisciplinary teams. Provides assessment, intervention, and consultative services to medical inpatients at the Valley Regional Hospital, Primary Care Persistent Pain Clinic, and Palliative Care and sees outpatients living with chronic medical conditions (e.g., cancer, diabetes, persistent pain, unexplained medical conditions). Treatment modalities include CBT, ACT, and psychoeducation (pain neuroscience education).

Tara Szuszkiewicz, Ph.D., University of Windsor, 2001. Child and Youth Mental Health. Assessment and treatment of children and youth with a focus on autism spectrum disorders and other developmental disabilities.

Other Members of the Discipline of Psychology

Liz Fraser, M.Sc., Candidate Register, Acadia University 2016. Adult Mental Health. Mood and Anxiety, Addictions.

Melissa Smith, M.A., University of Waterloo, 1999. Child and Youth Mental Health. Psychometric testing includes developmental assessments and learning screening. Assessment and treatment of young children with Autism Spectrum Disorder. Special interests in behavioural interventions and anxiety disorders.

Stephen Theriault, M.Sc., Acadia 1998. Child and Youth Mental Health. Assessment of ADHD, treatment of anxiety disorders including PTSD, and emerging personality disorders in adolescents.

TELEPHONE NUMBERS

Primary Line: 1-855-273-7710

CHIPMAN: (902) 365-1701 (use extensions below)

VALLEY REGIONAL HOSPITAL (VRH): (902) 678-7381

SOLDIERS MEMORIAL HOSPITAL (SMH): (902) 825-6160

NAME	OFFICE LOCATION	TEAM	PHONE EXT.
Jeff Bailey	KMHC	Adult	2961
Glen Berry	KMHC	Adult	2869
Alison Bertoia	KMHC	Adult	1716
Terri Cordwell	KMHC	C&Y	2908
Liz Fraser	KMHC	Adult	2412
Omeed Ghandehari	KMHC	Adult	2410
Julie Longard	SMH	C&Y	1762462
Victoria Pitura	KMHC	Adult	TBD
Colin Pottie	VRH	Adult	
Melissa Smith	KMHC	C&Y	2886
Tara Szuszkiewicz	SMH	C&Y	1762466
Stephen Theriault	SMH	C&Y	1762474

SMH = Soldier's Memorial Hospital, Middleton

KMHC = Kentville Mental Health Clinic (Chipman)

EKM = Eastern Kings Memorial, Wolfville

VRH = Valley Regional Hospital, Kentville

C&Y = Child & Youth

3. PRE-DOCTORAL RESIDENCY IN PSYCHOLOGY

3.1 Purpose

Two pre-doctoral Residency positions are offered each year; typically, the residency offers one position with a child and adolescent focus and one position with an adult focus. The purpose of both year-long Residencies in clinical psychology is to enable doctoral level students to complete their professional degree requirements in a semi-rural setting emphasizing comprehensive health care and breadth of experience. We provide Residents with a broad experience over the Residency year and help them develop an understanding of issues relevant to practice in a semi-rural area. For example, Residents learn to practice as a generalist with respect for limits of competence while still developing specialty skills and become familiar with handling ethical issues prevalent in a semi-rural setting (e.g., dual relationships and challenges with respect to confidentiality). Health promotion programs and building relationships with community partners are key components to the delivery of our mental health services. Our program strives to further the development of Residents' competence in the areas of assessment; intervention; interpersonal skills and intrapersonal awareness; awareness, knowledge, and application of ethical and professional principles necessary for independent practice; and research through protected time for completing dissertation work or working on publications and/or through program evaluation opportunities.

3.2 Structure

The residency program is developed and structured with the intention of helping our Residents develop in accordance with the scientist practitioner model. To facilitate this, the Resident experience aims to emphasize clinical, educational, and research activities.

Clinical Activities

The pre-doctoral Residency positions are full-time positions designed to provide broad, general training in delivering mental health services to adults and/or children and youth in a semi-rural outpatient setting. Residents must select and apply to either the adult or child and youth track based on their experience and interest. Residents are expected to participate in compulsory minor rotations associated with their track of training. Further, elective rotations and experiences offer more opportunity for in-depth training with specialized populations/programs, again in a semi-rural setting. Residents spend four days per week involved in clinical activities. Direct services such as direct patient contact, consultation and report writing should not exceed 2/3 of the Residents' time. Residents are required to record time spent in clinical and nonclinical activities using the "Time 2 Track" program available online. To ensure breadth of experience and training over the course of the Residency year Residents are expected to provide assessment, individual and group therapy using more than one therapeutic modality, and participate in at least one health promotion activity. Residents are also expected to gain experience working with clients with a presenting problem outside of the mandatory experiences (e.g., PTSD, health, severe and persistent mental illness). See both the descriptions of Primary and Minor Rotations and the Psychology Residency Tracking Grid (Appendix A) for additional information on mandatory experiences.

Education Activities

Residents are expected to attend a mandatory Annapolis Valley (AV) seminar series (select Friday afternoons) focusing on professional and clinical issues, especially those relevant to the delivery of mental health services in a semi-rural area. In addition, Residents participate in a province-wide seminar series (7-9 Friday afternoon talks) that include Residents from the other two residency training programs in the province (i.e., the Halifax Clinical Psychology Residency Program and the Izaak Walton Killam Health Centre (IWK; Halifax)). Following the province-wide seminars, Residents from all training programs participate in a peer support session for Residents only. This provides the opportunity for Residents to interact and discuss issues related to their Residency experience. Typically, they last 30 minutes, with

Residents developing the format. Residents are also welcome to attend a second metro-wide seminar series for Residents from the Halifax-Dartmouth sites when scheduling permits. Travel is required for the province- and metro-wide seminar series. Transportation costs up to \$500.00 are covered by the residency program. A schedule for all three seminar series is provided at the beginning of the Residency. Residents are asked to complete evaluations for all seminars to assist with planning future seminar series.

Residents are encouraged to attend relevant Psychiatry Rounds and Medicine Rounds broadcast to VRH from the QEII. The Department of Medicine at VRH also host rounds that are broadcast to other hospitals in the region.

Residents are encouraged to take advantage of educational opportunities at Acadia University (e.g., colloquia) located in Wolfville and workshops and colloquia located in the Halifax-Dartmouth area. Residents are eligible for five days of paid educational leave. Costs to attend conferences /training workshops would be incurred by the Resident. Time off to attend must be negotiated with the current supervisor.

Research Activities

One day per week is protected for research/program evaluation throughout the residency year. Residents who have not yet defended their dissertation are encouraged to use some of this time to work on completing final drafts of their dissertations or publications. Opportunities exist to develop and carry out program evaluation of numerous programs/projects within Mental Health & Addictions Services.

Some research time can be protected for literature reviews relevant for client care. Residents have access to library services for literature searches and access to empirical journal articles.

4. PRIMARY TRACKS AND ROTATIONS

The predoctoral residency offers two primary tracks of training:

- Adult Mental Health (1 position)
- Child and Adolescent Mental Health (1 position).

Applicants are asked to apply to one of the two tracks. *Please note as well that the NSHA Annapolis Valley residency program recognizes the importance of life-span training; thus, applicants who successfully match to the adult mental health track are encouraged to participate in some contained child and adolescent work (e.g., shadowing/co-facilitating group) during their residency year and vice versa.*

4.1. Adult Mental Health Track

Residents are a member of the outpatient Adult Mental Health team that services adults with mental health problems in a semi-rural setting (Kings and Annapolis Counties). The multidisciplinary team consists of social workers, nurses, community support workers, psychiatrists, and psychologists (six doctoral level and one masters level) primarily working out of two sites: Kentville (Chipman Building) and Middleton (Soldiers Memorial Hospital). In addition, team members provide services in the local hospitals and various satellite sites (smaller health centres) across the Valley. Residents are assigned an office at the Chipman Building and may periodically attend other sites such as the Valley Regional Hospital or other satellite clinics for a specific task (e.g., consultation, meeting, presentation) or rotation. but could be involved in work at the Valley Regional Hospital or other sites.

Residents are expected to participate in the regular clinical duties of a general clinician (i.e., carry a caseload) in addition to participating in Minor Rotations (see descriptions below), and any Elective Rotations of interest (see descriptions below). As members of a multidisciplinary team, residents will attend meetings, collaborate in the

development and delivery of group programming, and provide case consultation as needed. Clients may present with any number of problem areas. Most often, residents receive exposure to clients presenting with Anxiety Disorders, Mood Disorders, Personality Disorders, and Adjustment/Life Issues; however, depending on availability and interest, there may be opportunities to work with clients presenting with PTSD, Eating Disorders, or Addictions issues. Elective rotations will also include other specific problem areas such as Psychosis or coping with various Health problems.

Residents are responsible for providing intake assessments and on-going assessment as necessary, providing consultation to other clinicians, and/or connecting with other service providers as appropriate. While recognizing potential barriers (e.g., client availability), client assignment to residents is guided by residents' training and learning goals. Opportunities to gain experience with crisis intervention; and provide psycho-educational workshops or community presentations may be arranged.

Compulsory Rotations

Mood and Anxiety Disorders

The purpose of the Mood and Anxiety Disorders rotation is to provide residents with experience in treating these mood and anxiety disorders from Cognitive Behavioral and Acceptance Commitment approaches. Residents are expected to participate in the development and delivery of transdiagnostic Cognitive-Behavioral and Acceptance-Commitment group programming for clients with primary diagnoses of an anxiety or unipolar mood disorder. Residents will also carry an individual caseload of such clients (number to be negotiated in the context of other goals) from initial assessment to discharge, and involve other clinicians as appropriate. For those residents who also express interest in the *Training in Supervision* rotation (see below), they may also be asked to supervise Master of Science Clinical Psychology students in the delivery of group and individual treatment.

Duration: 1 to 2 days/week for 4 to 12 months.

Brief Screening and Intervention

The purpose of the brief assessment and intervention rotation is to give Residents practical experience in the rapid assessment of client symptoms, goals, and appropriateness for mental health services. This purpose is achieved by exposing Residents to *Choice Appointments*. Choice appointments are relatively brief intake appointments within the CAPA Model during which client's goals and symptoms are reviewed and appropriateness for Outpatient Adult Mental Health service is established. For those who are appropriate for further service, the Choice appointment serves as a treatment matching appointment in which the client is referred to the appropriate service and clinician. For those not appropriate for further service, the appointment may serve as a brief intervention through psychoeducation, introduction to self-help material, and redirection to more appropriate resources.

Within this rotation, Residents will gain exposure to a broad range of presenting concerns ranging from psychosocial stressors to diagnosable mental health conditions and have the opportunity to differentially assess for symptoms, determine "fit" with Outpatient Mental Health inclusion criteria, and provide direction for appropriate next steps. Residents will also be exposed to the writing of Choice Letters, session summary letters written to the client as reminders of the session's content and next steps. Through this, Residents will gain experience in the brief screening of mental health diagnoses, be further exposed to the CAPA Model of delivery, and become familiar with available community resources.

Duration: ½ day/week for 3 to 6 months.

Adult Assessment

The purpose of the adult assessment rotation is to give Residents practical experience in using formal psychological tests to clarify diagnosis in mental health outpatient and inpatient settings. Key skills emphasized in this rotation include refining the referral question, assessment interviewing, reasoning through appropriate test measurements, test administration and scoring, interpretation of results, and case conceptualization. Along with these skills, Residents gain exposure to a broad range of psychopathology through referrals for testing from both outpatient and inpatient mental health units. Through this rotation, Residents will have opportunities to interview inpatients with a range of diagnoses, including major depression, anxiety, schizophrenia and other psychoses, bipolar disorder, and a range of personality disorders. Whenever possible, Residents will further develop their knowledge of psychopathology and the discrimination between various possible diagnoses using test measurements. Specialized assessments can usually be arranged, when available, for Residents who have a particular interest in Early Psychosis, Eating Disorders, Adult ADHD, Dementia, and Child and Youth Assessment.

Most referrals for assessment come through outpatient mental health and the majority of testing takes place there. Referrals either come from physicians or from other mental health clinicians seeking diagnostic clarification. Specialized protocols are used for questions of Adult ADHD and personality disorders. Other common diagnoses are depression and anxiety disorders. Referrals can also come from the Inpatient Mental Health Unit. The Inpatient Mental Health Unit is an 8 bed, acute psychiatric assessment and treatment center. Average length of stay is usually a week and the most common diagnoses on the unit are psychosis, major mood disorder, or dementia. It is not uncommon for personality disorders to be diagnosed through the assessment process.

Residents will be expected to become familiar with the use of both cognitive tests and personality/psychopathology tests. Cognitive tests include the WAIS-IV, and may also include the WMS-III, WJD-III, RBANS, DKEFS, and CPT3 as needed. Personality tests include at least two of the following: MMPI-2, MCMI-III, BPI, NEO-IP3, or PAI. Opportunity for exposure to the Rorschach Inkblot Test (Exner Scoring system) is available; advanced training in the Rorschach is available to Residents who already have a basic working knowledge of the Exner Scoring system. Although structured interviewing is not a regular component of clinical work in NSHA Annapolis Valley, the SCID-5 is available for training purposes.

Residents seeking Child and Youth testing experience may have an opportunity to use the WISC-V, WIAT-III, MMPI-A and other measures that may be deemed appropriate.

Residents are expected to carry out and/or supervise one assessment per week. This usually includes an interview, test administration and scoring, feedback to clients, and appropriate documentation. All test results are discussed weekly in a testing clinical lab format attended by supervising psychologists, Residents, and Master's Students. During the testing clinic lab, interview and testing data is reviewed, diagnoses are reached, and conceptual models of the client's difficulties are developed. Individual supervision for Residents is also available to discuss particular issues regarding complicated testing and matters related to the provision of supervision carried out by the Resident. During the course of the rotation, Residents will be expected to carry out at least one multi-test assessment and write up an integrated test report.

Those residents who express interest in the Training in Supervision rotation, will also have the opportunity to supervise Masters level Clinical Psychology students who are completing an assessment practicum.

Duration: 1 day per week (6 months to 1 year)

Elective Rotations

Health Psychology

Psychological services are provided to individuals living with a range of chronic medical illness including cancer, cardiac disease, diabetes, multiple sclerosis, chronic pain, and gastrointestinal difficulties. Services are provided to adult outpatients through the outpatient referral process and medical inpatients through hospital consultations. Reasons for referral include coping with a chronic illness, lifestyle modification, stress management, adherence issues, anxiety and depression. There are also partnerships with several hospital-based programs such as the Cardiac Rehab program, Persistent Pain Clinic, Pulmonary Rehab program, Palliative Care, and the Diabetes Centre.

Residents will work with adults on an outpatient basis and gain experience in the following areas:

- Diagnostic and treatment issues associated with a variety of physical illnesses.
- Assessment and development of treatment plans in the area of Health Psychology
- Facilitation of psychoeducational sessions and groups (Cardiac Rehab, Chronic Pain Self-Management Program, COPD Rehab)

Depending on interest and availability, additional opportunities may include completing inpatient consultations and attending team rounds on the Medical and/or Surgical Unit at Valley Regional Hospital

Duration: 1 day per week for 6-12 months

PTSD Clinic

The PTSD clinic is composed of a group of psychologists and social workers who provide evidence-based treatment for clients presenting with PTSD. Treatment is provided via Prolonged Exposure (PE), Cognitive-Processing Therapy (CPT), and EMDR modalities. The clinicians involved meet weekly to triage and assign cases, as well as to discuss assessment and treatment related issues. The resident will have the opportunity to participate in weekly meetings and to carry a caseload of one or two clients and receive supervision from PE and CPT perspectives.

Duration: ½ day per week for 6 to 12 months.

DBT-informed Coping Skills Group

The adult mental health program provides opportunity for residents to participate in a DBT-informed skills group (emotion regulation; interpersonal effectiveness; mindfulness). Residents may choose any number of these to co-facilitate or lead throughout the Adult mental health rotation.

Duration: ½ day per week for approximately 4 months.

Training in Supervision

Residents may be able to gain some experience in supervision. This will be contingent on several factors including the availability of clinical psychology graduate practicum students. Training in supervision will be restricted to areas in which the Resident has received prior supervision or has expertise. The Resident must maintain satisfactory progress toward all other goals and objectives.

Residents may supervise all aspects of a clinical case or limited aspects (e.g., administration of certain tests / specific intervention). Residents will be involved in the evaluation of the practicum student but the overall responsibility for the evaluation lies with the supervising psychologist. Both the supervising psychologist

and the practicum student will evaluate Residents’ supervisory activities. Training in supervision will be incorporated into Residents’ supervision. The supervising psychologist is ultimately responsible for the practicum student and their activities. Time spent providing supervision to a practicum student will be considered direct service time.

Duration: ~ ½ day per week (availability and length is dependent on availability of supervisees).

Sample Weekly Schedule

The following is an example of a possible weekly schedule for a typical Resident with Adult Mental Health. This schedule would represent a resident who is currently active with the Mood and Anxiety, Assessment, Brief Screening and Intervention, and Training in Supervision minor rotations.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:30 – 9:00	Admin Time				
9:00-10:30	Therapy Client	Peer Supervision	Adult Assessment Testing Clinic	Brief Screening and Intervention Sessions (Choice)/ Supervision	Protected Research Time
10:30-12:00	Therapy Client	Adult Team Meeting			
12:00 – 1:00	Lunch				
1:00 – 2:30	Therapy Client	Mood & Anxiety Supervision	Therapy Client	Supervision of Master’s Student	Seminar and Peer Support
2:30 – 4:00	Supervision	Mood & Anxiety Group	Admin Time	Admin Time	
4:00 – 4:30	Admin Time				

4.2. Child and Youth Mental Health Track

Residents are members of the outpatient Child and Youth Mental Health team that services the majority of children and youth with mental health problems in a semi-rural setting (Kings and Annapolis Counties). The multidisciplinary team consists of social workers, nurses, community support workers, occupational therapists, and psychologists (two doctoral level and two master’s level) working out of two sites: Kentville (Chipman Building) and Middleton (Soldier’s Memorial Hospital). In addition, some team members provide services in local schools, hospitals, and/or medical offices. Residents are assigned office space in the Chipman Building and may be asked to attend other sites (e.g., schools or satellite clinics) for specific tasks (e.g., school meetings, consultations) or rotations.

Residents would be expected to participate in regular clinical duties of general clinicians (i.e., carry a caseload) in addition to participating in Minor Rotations (see descriptions below). Clients could present with any disorder of infancy, childhood, or adolescence, and Residents would be responsible for providing intake assessments, intervention, and treatment monitoring. When appropriate, Residents will be expected to facilitate referrals to other service providers. While recognizing barriers (e.g., client availability), assignment of clients will be driven by Resident interest and training. Residents may also have the opportunity to consult with Youth Workers in Addictions Services regarding substance use/abuse and to work with Community Support Workers to coordinate interventions in the home environment. Residents may have the opportunity to get experience in crisis intervention. Residents who are expected to participate in both of the compulsory minor rotations (Disruptive Behaviour Disorders Rotation and Anxiety Disorders) and will have the option to participate in other elective rotations if interested. There may also be opportunities for Residents in the Child and Youth Mental Health Track to participate in the Adult Assessment Minor Rotation and gain further experience in child and youth testing.

Developmental and Biopsychosocial frameworks are used in assessment and intervention. The majority of assessment experiences include clinical interviewing and standardized behavioural measures. However, Residents can gain some experience with cognitive, academic, and personality testing as well. Intervention experiences primarily include Behavioural, Cognitive-Behavioural and Family Systems approaches. Residents will be members of a multidisciplinary team (i.e., attend meetings; collaborate in offering groups; provide case consultation as needed). Residents are expected to work with those involved in the client's care (i.e., parents, teachers, other service providers such as early intervention associations, physicians/pediatricians, speech and language pathologists, occupational therapists, etc.) to provide the best possible service for the client.

Compulsory Rotations

Disruptive Behaviour Disorders

Residents will gain experience with assessment and differential diagnosis of disruptive behaviour disorders (i.e., ADHD, ODD, Conduct; and co-occurring conditions) and intervention. Assessment includes interviewing classroom teachers and may include opportunity for school observations and cognitive/academic testing. Residents will gain experience in providing assessment feedback and education regarding diagnoses to client, parents, physicians, and schools. Treatment includes collaborating with those involved in the child's care to develop behavioural plans and may include sitting in on psychiatric consultations. Residents may have an opportunity to participate in the ADHD Education Clinic for parents of children newly diagnosed with ADHD. Residents observe and/or participate in parenting courses regarding behavioural management.

Duration: ~1-2 days per week for 12 months

Anxiety Disorders

Residents will gain experience with the assessment and differential diagnosis of anxiety disorders including Social Phobia, Generalized Anxiety Disorder, PTSD, Separation Anxiety Disorder, and OCD. Residents will also gain experience providing intervention in individual and group contexts (i.e., Health promotion/prevention group for parents and CBT treatment groups for children, youth and their parents). Assessment may include using standardized self-report measures and personality testing. Intervention may include providing education and support to parents and working with school staff to help school refusing children and youth.

Duration: ~1-2 days per week for 12 months

Brief Screening and Intervention

The purpose of the brief assessment and intervention rotation is to give Residents practical experience in the rapid assessment of client symptoms, goals, and appropriateness for mental health services. This purpose is achieved by exposing Residents to *Choice Appointments*. Choice appointments are relatively brief intake appointments within the CAPA Model during which client's goals and symptoms are reviewed and appropriateness for Child and Youth Mental Health Services is established. For those who are appropriate for further service, the Choice appointment serves as a treatment matching appointment in which the client is referred to the appropriate service and clinician. For those not appropriate for further service, the appointment may serve as a brief intervention through psychoeducation, introduction to self-help material, and redirection to more appropriate resources.

Within this rotation, Residents will gain exposure to a broad range of presenting concerns ranging from psychosocial stressors to diagnosable mental health conditions and have the opportunity to differentially assess for symptoms, determine "fit" with Outpatient Mental Health inclusion criteria, and provide direction

for appropriate next steps. Residents will also be exposed to the writing of Choice Letters, session summary letters written to the client as reminders of the session's content and next steps. Through this, Residents will gain experience in the brief screening of mental health diagnoses, be further exposed to the CAPA Model of delivery, and become familiar with available community resources.

Duration: ½ day/week for 3 to 6 months.

Elective Rotations

Autism Spectrum Disorders

The autism team sees preschool and school-age children and youth referred for assessment of Autism Spectrum Disorders (ASD). Depending on interest and experience, Residents will observe and/or participate in ASD assessments using the ADOS-2 and ADI-R (in addition to gathering information from other sources), including communicating feedback to involved parties and diagnostic report-writing. Residents may also participate in cognitive assessments, functional behavioural analyses, and multidisciplinary individual family service plan meetings. Residents may participate in outpatient clinic interventions with school-age children and youth with ASD and/or observe in-home intensive Pivotal Response Training carried out by Autism Support Workers. Other interventions include behavioural and other consultations.

Duration: ½ - 1 day per week for 12 months

Neurodevelopmental Clinic

Depending on interest and experience, Residents will observe and/or participate in intakes and cognitive/academic testing for preschool children with suspected delays in specific areas or overall development. Residents will gain experience in providing verbal and written feedback regarding assessment results and recommendations to families and daycares/schools. Residents may get experience working with Community Support staff in developing behavioural plans and implementing such in the home.

Duration: ½ – 1 day per week for 12 months

Training in Supervision

Residents may be able to gain some experience in supervision. This will be contingent on several factors including the availability of clinical psychology graduate practicum students. Training in supervision will be restricted to areas in which the Resident has received prior supervision or has expertise. The Resident must maintain satisfactory progress toward all other goals and objectives.

Residents may supervise all aspects of a clinical case or limited aspects (e.g., administration of certain tests / specific intervention). Residents will be involved in the evaluation of the practicum student but the overall responsibility for the evaluation lies with the supervising psychologist. Both the supervising psychologist and the practicum student will evaluate Residents' supervisory activities. Training in supervision will be incorporated into Residents' supervision. The supervising psychologist is ultimately responsible for the practicum student and their activities. Time spent providing supervision to a practicum student will be considered direct service time.

Duration: ~ ½ day per week (availability and length is dependent on availability of supervisees).

Speciality Clinics

Residents may also have the opportunity to work with other disciplines to learn more about client care through our sub-specialty clinics: Diabetic Education Clinic, Early Psychosis Program.

Sample Weekly Schedule

The following is an example of a possible weekly schedule for a typical Resident with Child and Youth Mental Health. This schedule would represent a resident who is currently active with the Autism, Brief Screening and Intervention, and Training in Supervision minor rotations.

	Monday	Tuesday	Wednesday	Thursday	Friday
8:30 – 9:00	Admin Time				
9:00-10:30	Therapy Client	Peer Supervision	Autism Rotation	Brief Screening and Intervention	Protected Research Time
10:30-12:00	Therapy Client	Team Meeting		Assessment Client	
12:00 – 1:00	Lunch				
1:00 – 2:30	Therapy Client	Group Preparation	Autism Rotation	Supervision of Master’s Student	Seminar and Peer Support
2:30 – 4:00	Supervision	Group Facilitation		Admin Time	
4:00 – 4:30	Admin Time				

5. SUPERVISION

In accordance with the accreditation guidelines of the Canadian Psychology Association, Residents receive a minimum of four hours supervision per week. Supervision can include co-therapy, direct observation, and review of videotaped/audiotaped sessions. Residents may have two supervisors at the same time. In the event the Resident has two supervisors in one rotation, one will serve as DoT for that rotation, ensuring that the duties and responsibilities for the rotation are fulfilled. The four hours of supervision time will be divided between the supervisors. Residents are encouraged to provide ongoing feedback to supervisors to improve the supervisory relationship and training experiences. Complaints Procedures (Appendix B) are to be followed in the event of a conflict or complaint arising between a Resident and a supervisor (other than a conflict or complaint concerning evaluation, remediation, or termination).

5.1. Standards for Supervision

1. At the beginning of each rotation the Resident and supervisor(s) will draw up a Supervision Agreement (Appendix C). The purpose is to specify objectives (both those of the supervisor(s) and of the Resident), Residency activities, the method of supervision and the form of evaluation in order to provide focus for the rotations and facilitate supervisor-Resident cooperation and evaluation.
2. The supervisor(s) involved in the rotation (or in a separate component of the latter) is/are responsible for the completion of the Supervision Agreement, to be sent to the DoT no later than two weeks following the initiation of the rotation. Consultation with the Resident is essential and the development of the agreement must be a collaborative process.
3. The Supervision Agreement should contain (a) both supervisor and resident expectations and identification of both compulsory and optional experiences (b) the description of the method of supervision, (c) and the form of evaluation.

4. In order to meet CPA accreditation standard for supervision, Residents will receive a minimum of four hours formal supervision a week.
5. Supervisors are responsible to ensure that they have sufficient direct knowledge of Resident activities including an awareness of client problems and completion of appropriate documentation.
6. Residents must be formally evaluated at mid-rotation and end of rotation and reviewed with the Resident. It is the supervisor's responsibility to ensure that the written evaluations and feedback to the Resident are completed in a timely manner.
7. Supervisors are responsible for intervening as necessary should the Resident / client relationship become problematic.
8. Should problems occur in the supervisory relationship,
 - The supervisor and Resident will meet and attempt to resolve the problem. If not resolved,
 - The supervisor will arrange a joint meeting with the DoT. If not resolved,
 - The issue will be discussed with the Residency Committee, and either remediation procedures will be followed or there will be a change of supervisors.

6. EVALUATION

Evaluation should be an ongoing process throughout the Residency. Residents are evaluated formally at mid-rotation points and at the end of each rotation. Resident performance standards have been set for each rotation area (Appendix D). A contractual agreement is made between each supervisor and Resident specifying the expectations of each, compulsory and optional activities, and the methods of supervision and evaluation. An evaluation is based on comparison with both standards for successful completion of the Residency and the supervision agreement. Residents are expected to track their clinical activities (e.g., therapeutic modalities, populations served, etc.) with the "Time 2 Track" program available on line. Weekly print out of hours should be reviewed in supervision and submitted to the DoT.

Each supervisor completes a Resident Evaluation Form (Appendix E). The Resident has the opportunity to respond to this before the form is sent on to the DoT. Each supervisor meets with the Resident to do a mid-rotation and end of rotation evaluation. If significant problems are identified, the DoT must be notified and the problems must be documented. Remediation and Termination Procedures are followed in the event that a Resident's performance falls below expectations and Appeal Procedures are also to be followed if appropriate (Appendix F).

Supervisors are evaluated formally at the end of each rotation (Appendix G). Residents evaluate each rotation upon completion (Appendix H), as well as evaluating the Residency as a whole at the end of the Residency year (Appendix I). These evaluations are placed in sealed envelopes and are given to the DoT. They are not opened until the Residency year is completed. Once opened a copy is provided to the supervisor. The PPPL also views the evaluations. Supervisors are encouraged to give a verbal summary of the Resident's feedback to their units (if this seems appropriate). Should there be any concerns about the supervisor's performance (e.g., lack of availability for supervision, overly critical), the DoT and/or PPPL can choose to meet with the supervisor to discuss the issue further. Should the evaluations suggest some impropriety on the part of the supervisor (e.g., an ethical violation, abuse of the Resident), then the supervisor would be asked to meet with the DoT and PPPL to discuss this further.

7. EMPLOYMENT AND WORK LOAD PROCEDURES

7.1. Hospital/Clinic Policy

Residents are NSHA employees. Residents are required to have a Criminal Record Check, Vulnerable Sector Check, and Child Abuse Registry Check completed in their home province prior to starting residency. Residents are also required to meet with an Occupational Health Nurse to review health and vaccination history. The information shared with the Occupational Health Nurse is confidential. Residents should provide a record of vaccination history to the Occupational Health Nurse. Residents are required to go through a day-long hospital orientation (arranged by Personnel) usually shortly in advance of the residency start date (currently scheduled on Mondays biweekly throughout the year). The DoT will have completed a Management Self-Serve Form (MSS) and submitted it to Personnel so that Residents will be on the payroll.

7.2. Stipend and Benefits

The Residency begins September 1, 2019 and continues for 12 months, including three weeks' vacation, five days of paid educational leave, and accumulated sick leave benefits. Residents are required to work 37.5 hours per week. A gross stipend of \$35,000 is available for each of the two Residents. Should parking be required, the fee (approximately \$18.00/month) will be deducted from the Resident's pay and this can be arranged upon the Resident's arrival. The Resident's picture identification badge that is received following orientation will allow the Resident to exit the parking lot. Prior to that, Residents will need to pay a fee of \$3.00 for each exit. Travel money of up to \$500 to assist with travel to Halifax is available. Funding is not available for workshop or conference fees.

Residents get 15 days paid vacation that is to be taken during the Residency year, with the stipulation that no more than five days be taken during the first four months of Residency. Residents make requests for vacation to their supervisors. Vacation time is not to adversely affect either clinical care or the ability to provide supervision to practicum students.

Sick time is earned and accumulated at the standard rate (1-1/4 days per month) for a total of 15 days for the year. A "Request for Leaves of Absence" form is completed and submitted to the clinic facilitator for vacation or sick time.

7.3. Overtime Policy

The members of the NSHA – Annapolis Valley Psychology Residency Program view the development of healthy work-life balance as a priority goal for developing practitioners. As a result, the maintenance of healthy work hours is emphasized during the residency year. Thus, residents are encouraged and supported in the creation of a residency schedule that can be managed during regularly scheduled work hours. Given this, residents are discouraged from working additional hours, and requests to work extra hours are not generally approved unless there are exceptional circumstances affecting client care (e.g., offering or observing an evening group). In such instances, policy is to "flex" this time by working reduced hours on another day within the same two week pay period. Overtime slips are generally not completed by residents.

Brief monthly check-in's with the DOT are scheduled to review workload and make adjustments to maintain a healthy and manageable caseload.

7.4. Resources

Office space is available at each site. Also, Residents will have secretarial support and access to computer, internet, printer, photocopier and office supplies at each site. Residents will be assigned a phone number, voice mail, and

email address. In addition, Residents have access to each clinic's resource room that houses testing materials, books, videos and journals. There are also librarian services available through NSHA.

8. APPLICATION PROCEDURE

NSHA - AV Pre-doctoral Residency is accredited (initial accreditation 2012-2013). A 5-year accreditation term was recently granted following a site visit Spring 2017 by the Canadian Psychological Association (Accreditation Office – Canadian Psychological Association; 141 Laurier Avenue West; Suite 702; Ottawa, ON; K1P 5J3). We use the APPIC's computerized matching service and adhere to APPIC Match Policies. This Residency site agrees to abide by the APPIC policy that no person at this training facility will solicit, accept or use any ranking-related information from any Resident applicant. Completed applications should be received by **4:00 pm (Atlantic Time) on November 15th, 2020**. Applicants are notified of interview status on **December 4th, 2020 with follow-up contact to finalize interview dates and times beginning on December 7th, 2020**. Interviews are scheduled to take place between **January 3, 2021 and January 17, 2021**. The application should include the following:

- completed APPIC application form (can be downloaded from <http://www.appic.org/aapi>). In your cover-letter, please clearly specify the track to which you are applying (i.e., adult or child track).
- curriculum vitae, describing all relevant professional experience
- official transcripts of all graduate work
- two letters of recommendation from those familiar with the applicant's background in psychology and the completed letter from the Director of Clinical Training or the Head of the Psychology Department that is part of the APPIC application. Letters should be in the format required by APPIC.
- applications should be addressed to:

Dr. S. Jeffrey Bailey, R. Psych.
Director of Training for Psychology
Adult Mental Health Program
Mental Health and Addictions Services
Nova Scotia Health Authority
5 Chipman Drive
Kentville, NS B4N 3V7
Email: Jeff.Bailey@nshealth.ca
- In line with the recommendations of APPIC and the Canadian Council of Professional Psychology Programs, **all interviews will be conducted virtually.**

Revised: August, 2020 for the 2021-2022 training year

Therapy Modality Legend	
Cognitive Behaviour Therapy	CBT
Behaviour Therapy	B
Motivational Interviewing	MI
Health Promotion	HP
Dialectical Behaviour Therapy	DBT
Mindfulness	M
Interpersonal Therapy	IPT
Solution Focused Therapy	SF
Family Systems	S
Narrative Therapy	N
Object Relations Therapy	OR
Psychodynamic	P
Integrative	I
Emotion Focused Therapy	EF
Acceptance and Commitment Therapy	ACT
Dialectical Behavioural Therapy	DBT

Full Year Requirements:

Individual treatment

Group treatment

Assessment

More than one therapeutic modality

At least two different age groups

*Mandatory experience for adult

**Mandatory for child

One problem area in addition to mandatory experiences

One health promotion activity

Appendix B

COMPLAINTS PROCEDURES

In the event of a conflict or complaint arising between a Resident and a supervisor (other than a conflict or complaint concerning evaluation, remediation or termination), the following steps should be followed:

1. The concern should be discussed by the Resident and supervisor.
2. If this discussion does not lead to a satisfactory result, the concern should be expressed to the DoT who will meet with the Resident and supervisor to discuss the matter further. When the supervisor is also the DoT, the Resident would express the concern to a designate (the PPPL).
3. A resolution plan will be developed and implemented within a reasonable time period.
4. At the end of that period, the DoT (or designate) will meet separately with the Resident and supervisor to assess satisfaction with resolution of the concern.
5. If either the supervisor or Resident still have a concern, a meeting will be held between the Resident, the supervisor, the DoT (or designate), and the PPPL. Again an attempt to develop a resolution plan should be made, a time period set, and a review meeting held to determine the success of the plan.
6. If a satisfactory solution has still not been reached by the review meeting, the Residency Committee will be notified and action, as appropriate, will be taken. For example, the Resident might be given the option of working with another supervisor or the supervisor might be given the option of no longer working with the Resident.

Appendix C

PRE-DOCTORAL RESIDENCY IN PSYCHOLOGY
SUPERVISION AGREEMENT

Resident:	Supervisor:	
Evaluation Point (circle):	Mid Rotation	End Rotation
Major Rotation (circle):	Adult	Child
Period of Rotation (circle):	6 months	12 months

I. Objectives

A. Supervisor's Expectations:

The Resident will complete the following Minor Rotations (check):

- Disruptive Behaviour Disorders** (Child & Youth)
Involving: _____
- Anxiety Disorders** (Child and Youth)
Involving: _____
- Mood and Anxiety Disorders** (Adult)
Involving: _____
- Assessment** (Adult/Child & Youth)
Involving: _____
- Program Evaluation** (Adult/Child & Youth)
Involving: _____

The Resident will complete the following Elective Rotations (check):

- Autism Spectrum Disorders** (Child & Youth)
Involving: _____
- Neurodevelopmental Assessment** (Child & Youth)
Involving: _____
- Speciality Clinics** (Child & Youth): _____
Involving: _____
- Health Psychology** (Adult)
Involving: _____
- Early Psychosis** (Adult/Child & Youth)
Involving: _____
- Skills Building Groups** (Adult) : _____
Involving: _____
- Supervision of students** (Adult)
Involving: _____

- The Resident will conduct _____ Choice Appointments (i.e., initial contact appointments) and write Choice Letters.
- The Resident will demonstrate competence in the clinical assessment/case formulation/treatment planning process with clients in a rural setting, with approximately ___comprehensive clinical interviews.
- The Resident will demonstrate competence in the complete documentation of the above items

(Psychological Assessment Reports and/or Partnership Summary Letters).

- The Resident will administer and interpret relevant psychological tests appropriate for diagnostic and treatment planning.
- The Resident will demonstrate the ability to design and conduct individual treatment programs to address a range of presenting problems by carrying a therapy case load of ____ clients.
- The Resident will maintain timely and appropriate documentation of these activities (i.e., progress notes, Time to Track record keeping, Residency Tracking Grid).
- The Resident will spend between 1/3 to 2/3 of their time providing direct psychological service to clients.
- To become familiar with and utilize interventions from a variety of theoretical models, specifically:_____
- The Resident will demonstrate the ability to understand and utilize appropriate adjunctive treatment options (e.g. medical consults, transfers to other disciplines or specialty groups) and to consult with other professionals of AVH and in the community regarding client care as appropriate.
- The Resident will demonstrate familiarity and adhere to mental health standards in the Province of Nova Scotia (e.g. Mental Health Act, Hospitals Act); and AVDHA standards, policies and procedures.
- Adherence will also be maintained to Standards for Service Providers and ethical standards maintained by the provincial licensing body as well as APA or CPA.
- The Resident will use Friday mornings to work on completing Dissertation research and/or complete Program Evaluation Project on-site. The resident will attend both in-house and provincial seminars as scheduled on Friday afternoons.

B. Resident's Expectations:

II. Method of Supervision

- A. Hours:** Individual: Regularly scheduled weekly - ____ hours
 Group Supervision: Regularly scheduled weekly - ____ hours
 Peer Supervision: As deemed appropriate/necessary with fellow residents (AVH and provincial)
 Informal supervision: available at all times as needed

B. Preparation required:

Oral summaries, case notes/files, assessment materials, report drafts, audio/video tapes, Time to Track weekly reports

C. Style of supervision:

Direct observation
 Case discussion and review of progress notes and reports
 Video/audio tape of assessment/treatment sessions

III. Form of Evaluation

A. Criteria:

Following residents and supervisors agreed upon objectives (see above)

B. Mode:

Informal evaluation provided through supervision

Formal evaluation at mid rotation and end rotation points (e.g., see all necessary evaluation forms in the Pre-doctoral Residency in Psychology Manual)

C. Method of appeal:

As outlined in the Pre-Doctoral Residency in Psychology Manual

(supervisor) and (resident) agree to the conditions of the above contract, with the option of modification if mutual agreement is reached.

Date:

Signatures:

Appendix D

GENERAL STANDARDS FOR SUCCESSFUL COMPLETION OF THE RESIDENCY

In accordance with CPA criteria, Residents are provided with written standards for completion of the Residency, and are informed in writing of any discrepancy between their functioning and the program's minimum standards.

In order to complete the Residency successfully, the Resident must be able:

1. To demonstrate knowledge of the Canadian Code of Ethics for Psychologists and the CPA Standards for Providers of Psychological Services, and to apply these standards in clinical decision-making.
2. To conduct a diagnostic interview in which the Resident establishes rapport, makes observations, gathers essential information, clarifies the patient's problems by inquiry and formulates a diagnosis.
3. To complete a comprehensive but concise written intake assessment report according to the AV guidelines.
4. To administer, score, and interpret proficiently standardized psychological tests of intelligence, personality, psychopathology, aptitude, cognitive style, etc., which are appropriate to assess clinical problems encountered during the Residency.
5. To demonstrate case conceptualisation skills, describe major features of common psychological problems, conceptualise problems as a function of the interaction of biological, social, cognitive, and interpersonal factors, and present this conceptualisation in a clear diagnostic formulation.
6. To produce clear, succinct psychological assessment reports in which behavioural observations, interview responses, test results, and data from other sources are integrated as needed.
7. To establish a therapeutic alliance and formulate a realistic treatment or management plan.
8. To conduct individual psychotherapy at a level of proficiency sufficient for independent practice, as well as demonstrating basic skills in group, marital and/or family therapy as appropriate.
9. To demonstrate a variety of theoretical perspectives, a range of intervention skills, and an understanding of the therapeutic process.
10. To evaluate and manage psychological crises such as suicide threats.
11. To provide competent psychological consultation to other professionals, program administrators, teachers, etc. and to effectively communicate (either verbally or written) the results of the consultation.
12. To identify and manage one's own response to patients and recognize how this affects assessment and treatment.
13. To relate to patients in a way that respects their dignity (as discussed in the Code of Ethics) and treats fellow trainees, supervisors, and other professionals in a respectful manner.
14. To evaluate one's own performance, use feedback effectively and be receptive to supervision.
15. To demonstrate an awareness of limitations and ask for help or consultation from colleagues and supervisors when appropriate.

16. To display an understanding of confidentiality issues, consent to treatment and how to deal with ethical dilemmas.
17. To manage time effectively including the efficient and timely completion of tasks.
18. To identify appropriate community resources and those within the facility.

STANDARDS FOR SUCCESSFUL COMPLETION OF SPECIFIC ROTATIONS

Each rotation has also developed a set of standards based on the general standards described in the previous section. In order to successfully complete the identified rotation, the Resident will be expected to be able to competently perform the following:

Adult Mental Health Rotation

1. Comprehensively assess patients on intake so that a preliminary diagnostic impression and treatment plan can be formulated.
2. Be aware of symptoms that would require referral to a medical practitioner or to another mental health professional.
3. Select, administer, score and interpret those psychological tests which are appropriate to assess clinical problems encountered.
4. Effectively communicate feedback to the patient, family, and/or referring agent regarding assessment in a manner that is meaningful to them.
5. Produce clear, comprehensive Intake Assessments and formal assessment reports following AV Mental Health Division guidelines.
6. Manage a caseload of outpatients (average 20 for full year rotation, but may decrease according to group treatment activities), including individual, couples and family therapy as appropriate.
7. Revise treatment plans based on ongoing evaluation of patient's progress.
8. Document progress notes of ongoing therapy and submit paperwork, MHOIS etc. in a timely manner.
9. Participate in referral meetings, team meetings and clinical case conferences.

Child and Youth Mental Health Rotation

In addition to the general standards, the standards for this rotation assume those of the Adult Mental Health Rotation and add:

1. Liaise with professionals outside hospital (e.g., schools).
2. Demonstrate an awareness of special ethical issues in working with children and adolescents (e.g., abuse reporting, confidentiality, and consent).
3. Work effectively with parents of patients.

Health Psychology Rotation

In addition to the general standards and those for the Adult Mental Health Rotation, those specific to the Health Psychology Rotation are as follows:

1. Conduct clinical interviews with medical patients designed to establish rapport, educate, and facilitate treatment.
2. Demonstrate an understanding of various chronic medical illnesses and incorporate that knowledge into the conceptualisation of psychological problems in a medical population.
3. Demonstrate an awareness of specific issues of medical patients such as adherence and chronicity.
4. Provide effective psychological consultation to other professionals and document as appropriate.
5. Provide rapid urgent consultations for medical inpatients.
6. Formulate realistic treatment or management plans that incorporate models of change and/or lifestyle modification issues.
7. Conduct psychoeducation sessions / group treatments for medical patients.

**Appendix E
AV PREDOCTORAL RESIDENCY**

Evaluation of Resident

Resident: _____

Supervisor: _____ **Rotation:** _____

Period of Evaluation: _____ **Date Completed:** _____

Please mark an X by any activities in which you supervised this Resident.

Assessment
 Individual Therapy
 Group Therapy
 Couple Therapy
 Family Therapy
 Presentations
 Consultation
 Other (Specify)

Please rate the Resident's performance in each of the skill areas by circling the appropriate number. Note that you must provide comments should you select "1" as your rating. Your comments must specify the nature of the deficit, as well as suggest remediation.

	Unsatisfactory/ Needs Much Improvement	Satisfactory/ Meets Expectations	Above Standards/ Exceeds Expectations	Not Applicable/ Not Assessed
<hr/>				
<u>Assessment</u>				
Interviewing skills -----1		2	3	na
Ability assessment -----1		2	3	na
Personality assessment -----1		2	3	na
Diagnostic skills -----1		2	3	na
<u>Intervention</u>				
Case conceptualisation -----1		2	3	na
Develop treatment plan/goals ----1		2	3	na
Individual therapy -----1		2	3	na
Couple therapy -----1		2	3	na
Family therapy -----1		2	3	na
Group therapy -----1		2	3	na
Crises management -----1		2	3	na

	Unsatisfactory/ Needs Much Improvement	Satisfactory/ Meets Expectations	Above Standards/ Exceeds Expectations	Not Applicable/ Not Assessed

<u>Additional Clinical Skills</u>				
Consultation to clients-----1		2	3	na
Consultation to professionals -----1		2	3	na
Research/Program evaluation -----1		2	3	na
Presentation skills -----1		2	3	na
Communication skills -----1		2	3	na
Report writing -----1		2	3	na
Appropriate documentation -----1		2	3	na
<u>Inter/Intrapersonal Skills</u>				
Develop/maintain therapeutic alliance -1		2	3	na
Professional relationship with staff -----1		2	3	na
Openness/receptivity to supervision ---1		2	3	na
Awareness of limits -----1		2	3	na
Awareness of own response to clients --1		2	3	na
<u>Professionalism</u>				
Utilizes appropriate theory/research ---1		2	3	na
Leadership skills/initiative -----1		2	3	na
Time/caseload management -----1		2	3	na
Responsibility, reliability -----1		2	3	na
Efficiency, punctuality -----1		2	3	na
Ethical decision-making -----1		2	3	na
Commitment to psychology -----1		2	3	na
Professional development -----1		2	3	na
Overall evaluation of Resident -----1		2	3	na

Comments on items rated "Unsatisfactory/Needs Much Improvement":

Current areas of strength:

Current areas needing improvement, more practice, supervision or study:

Supervisor Signature _____ **Date** _____

Supervisor Signature _____ **Date** _____

Resident Signature _____ **Date** _____

Appendix F

REMEDIATION AND TERMINATION PROCEDURES

Measure of Successful Completion

Modal ratings by all supervisors of the Resident must be at or above the "Meets Expectations" point on all measures of competence and working style as shown in "Evaluation of Psychology Resident" form. When the modal rating achieved by the Resident at the end of a rotation is below the "Meets Expectations" rank, the Resident's performance is deemed to be lacking, and requires remediation.

Definition of Deficient Performance

A Resident's performance is deemed to be lacking at the end of a rotation if the rotation supervisors' modal rating of any of the competence areas assessed are below the rank of "Meets Expectations". The competence areas assessed correspond to the standards set for successful completion of the Residency.

Any gross violation of Psychology Discipline, Mental Health Division and/or AV policy and/or violations of CPA Ethical Guidelines deemed to be unworthy professional conduct may be grounds for immediate action.

In judging the student's aptitude and fitness for practice, the Residency Committee shall rely upon the information obtained through the review process outlined above and shall be guided by the following statement, adapted from the University of Saskatchewan, Department of Psychology's Policy on Evaluation of Student Competence:

Criteria for the Evaluation of Aptitude and Fitness for Clinical Practice:

The goal of the AV Residency program is to produce clinical psychologists who are thoroughly grounded in both the science of psychology and the methods of clinical practice. The Program also has an ethical and legal obligation to protect both the public and the profession from any foreseeable harm resulting from the professional activities of the predoctoral Resident. The Program offers advanced training relating to Core Competencies and areas of professional practice in clinical psychology in order to prepare students for clinical work. However, it is understood that, in addition to this training, students in the program must possess a basic aptitude and fitness for clinical practice, sufficient to allow them to meet the standards laid out in the Canadian Code of Ethics for Psychologists. Thus, Supervisors and the AV Residency program have a responsibility to evaluate students' performance and abilities in the Residents' professional and ethical conduct in the fulfillment of this program's requirements as outlined in section 3 (a to d) below.

A Resident may be deemed to have inadequate aptitude and fitness for clinical practice under any of the following circumstances:

- I. The Resident's conduct clearly and demonstrably impacts the performance, development, or functioning of the student; represents a risk to public safety; or damages the representation of psychology to the profession or public;
- II. The Resident has engaged in one or more serious violations of the Canadian Psychology Association's Code of Ethics, beyond those which would be expected given the student's level of training and professional experience;
- III. The Resident has demonstrated a pattern of behaviour which suggests significant deficits in any of the following areas:

- a. Interpersonal and professional competence (e.g., the ways in which Residents relate to clients/patients, supervisors, allied professionals, the public, and individuals from diverse backgrounds or histories);
- b. Self-awareness, self-reflection, and self-evaluation (e.g., knowledge of the content and potential impact of one's own beliefs and values on patients/clients, peers, supervisors, allied professionals, the public, and individuals from diverse backgrounds or histories);
- c. Openness to processes of supervision (e.g., the ability and willingness to explore issues that either interfere with the appropriate provision of care or impede professional development or functioning);
- d. Resolution of issues or problems that interfere with professional development or functioning in a satisfactory manner (e.g., by responding constructively to feedback from supervisors and/or Residency committee members/director; by the successful completion of remediation plans; by participating in personal therapy in order to resolve issues or problems).

Where any of the above conditions have been met, and it is deemed that the Resident is likely to benefit sufficiently from additional intervention, training, and/or supervision to allow him/her to function in accordance with the Canadian Code of Ethics, the Resident may be suspended or restricted in their participation in the program until such time as such remediation has taken place and the Resident is deemed to have demonstrated sufficient improvement in his/her abilities, conduct and/or behaviour.

Where any of the above conditions have been met and the Resident has failed to benefit from remedial training, intervention or supervision, or is deemed unlikely to benefit from such intervention, training, and/or supervision, the Resident shall be dismissed from the Residency program.

Remediation Policy

Format and Consent of Formal Remediation Plans

When deemed necessary by the criteria outlined in this document, a Remediation Plan will be developed by a committee appointed by the Residency DoT. The committee will develop the plan in consultation with the Resident, and this plan will be in written form, with copies to the Resident, Residency Committee members, and the Residency DoT. Dependent on the nature of the difficulty, the Director of Clinical Training at the Resident's home program may also be sent a copy. Formal remediation plans must be in writing and must include at a minimum:

- a. An outline of the specific skills or knowledge that is judged to be deficient.
- b. Specific goals for the remediation process.
- c. A defined mechanism whereby the Resident's progress in redressing the deficits will be evaluated. This mechanism will include a date by which the Resident will be re-evaluated with respect to these deficits.
- d. Specific steps to be taken by the Resident, and a statement about who is responsible for assisting the Resident in carrying out the remediation plan. The remediation plan will be put into place as soon as possible. If there is no significant improvement by the date outlined in the plan, a decision will be made by the Residency Committee about terminating the Resident's training. Such a decision would be made consistent with the policy on termination, and would be subject to appeal consistent with the policy on appeal.

Mid-Rotation and End of Rotation Procedures

Each supervisor evaluates the Resident's progress at mid-rotation, and at the end of the rotation. Formal documentation is required for both rotations. A formal Remediation Plan is to be developed when problems are judged to be serious. In the event that a Resident's performance is deemed to be deficient at the end of a rotation, a formal Remediation Plan will be developed as outlined in this document. The evaluation leading to the formulation of a remedial plan, or the remedial plan itself, may be appealed consistent with Residency policy.

End of Residency Procedures

It is unlikely that a serious deficit would be observed in the last rotation, since most skill deficits should be obvious at earlier stages in the Residency year, allowing time to redress the deficit. However, should there be a serious deficit at the end of the Residency, the Residency Committee would meet to determine whether this deficit is serious enough to consider failing or terminating the Resident.

Termination / Failure Policy

The decision to fail a Resident may be made on the basis of either gross unprofessionalism or failure to meet the standards set for successful completion of the Residency. This decision may be made during the course of the Residency year, in which case, the Resident's training may be terminated and the Resident failed; or the decision to fail may be made at the end of the Residency training year.

The decision to fail the Resident will be made by the Residency Committee as a whole. Such a decision would be made only when the issues involved are judged as sufficiently serious and unresponsive to remediation attempts. The rationale for making such a decision will be fully documented, and a written copy will be provided for all Residency Committee members, the Resident and the Clinical Training Program Director of the Resident's academic department. Consistent with Residency policy, the Resident has the right to appeal a decision to fail.

APPEAL PROCEDURES

The Resident has the right to appeal individual supervisors' evaluations, end of rotation evaluations, decisions related to remediation, and decisions to fail.

Appeal of Individual Supervisors' Evaluation

In the event that the Resident does not agree with the evaluation of an individual supervisor within a rotation, the matter may be referred informally to the DoT by either the supervisor or the Resident. If it cannot be resolved satisfactorily at that level, the matter will be referred by the DoT in writing to the PPPL, who, together with the DoT, will strike a committee of two other psychologists who have not been involved in the Resident's supervision for that rotation. The committee will make a decision in consultation with the Resident, the supervisor, the DoT, and the PPPL. This judgment will be in writing and will be given to the Resident, the supervisor, and the DoT. This decision is final. When the supervisor is also the DoT, the Resident would appeal to a designate (the PPPL).

Appeal of the End of Rotation Evaluation

In the event that a Resident does not agree with the rotation evaluation, the Resident may refer the matter in writing to the DoT, with a copy to the PPPL, outlining the reasons for disagreeing with the evaluation. The PPPL and DoT would then meet with the Resident in order to determine whether the difficulty can be resolved through such a meeting. If it cannot be resolved satisfactorily at that level, the PPPL, together with the DoT, would strike a committee of two other psychologists who had not been involved in the Resident's supervision for that rotation. They will make a decision in consultation with the Resident, the supervisors for that rotation, the DoT, and the PPPL. The judgement must be in writing and copied to the Resident, the DoT, and the PPPL. The decision is final.

Appeal of a Remediation Plan

The remediation plan is developed for purposes of remediation in a competency area that is seen as being deficient. The Resident may appeal this plan in writing to the DoT who would then bring the appeal to the attention of the Residency Committee and PPPL. The DoT and PPPL would then strike a committee of at least two psychologists who had not been active in the development of the remediation plan. In consultation with the Resident, DoT, remainder of the Residency Committee, and PPPL, the remediation plan would be reviewed. The committee would make a judgment in writing. The decision is final.

Appeal of a Termination / Failure Decision

Decision to terminate the training of a Resident is made by the Residency Committee as a whole. Should the Resident choose to appeal this decision, an Appeal Committee would be struck, chaired either by the Director of Clinical Training of the Psychology Department at the university that the Resident is attending, or an individual designated by the university Director of Clinical Training. This could be one of the DoTs from another Nova Scotia setting. Any individual so designated must be a registered psychologist who has undergone a predoctoral Residency, and who is not a member of the Residency setting. The chairperson will appoint a committee consisting of three psychologists who are registered in Nova Scotia, who have completed a predoctoral Residency, and who are not members of the Residency setting. The following guidelines are suggested in comprising this committee: one psychologist nominated by the DoT; one psychologist nominated by the Resident, and one psychologist nominated by the university Director of Clinical Training. This committee will make a decision in writing, and this decision will be final and binding.

Appendix G

EVALUATION OF SUPERVISION

RESIDENT: _____ **ROTATION:** _____

SUPERVISOR: _____

SUPERVISION PERIOD: _____ **DATE COMPLETED:** _____

NATURE OF SUPERVISION: _____

Please complete the following ratings:

Unsatisfactory/	Satisfactory/	Very Satisfactory/	Not Applicable	
		Below Average	Average	Above Average
		1	2	3
				na

Professionalism				
Accessible for regular appointments	-----1	2	3	na
Accessible for emergency consultations	---1	2	3	na
Accessible for informal consultation	-----1	2	3	na
Prepared for supervision sessions	-----1	2	3	na
Timely return of reports	-----1	2	3	na
Efficient use of supervision time	-----1	2	3	na
Appropriate assignment of duties	-----1	2	3	na
Supervisory Relationship				
Approachability	-----1	2	3	na
Support	-----1	2	3	na
Respect	-----1	2	3	na
Comfort level	-----1	2	3	na
Flexibility to alternative views, changes	----1	2	3	na
Encouragement to develop own style	-----1	2	3	na
Responsiveness to feedback	-----1	2	3	na

	Unsatisfactory/ Below Average 1	Satisfactory/ Average 2	Very Satisfactory/ Above Average 3	Not Applicable na
<hr/>				
<i>Quality of Supervision</i>				
Depth and breadth of knowledge -----1	2	3	na	
Provision of resource material -----1	2	3	na	
Balance of positive and negative feedback -1	2	3	na	
Directness of feedback -----1	2	3	na	
Clarity of expectations of you ----- 1	2	3	na	
Level of guidance ----- 1	2	3	na	
Usefulness of comments/suggestions ----- 1	2	3	na	
Helpfulness in appropriate case selection ---1	2	3	na	
Overall Quality of Supervision received -----1	2	3	na	

Please comment on any item rated "Unsatisfactory/Below Average":

Supervisor's areas of strength:

Supervisor's areas needing improvement:

Are there any changes in the supervisory process that would improve the quality of supervision being provided?

Are there unresolved problems in supervision that require the involvement of the Residency DoT? Please circle: YES NO

If YES, please elaborate:

Additional comments:

Thank you for your feedback.

Resident Signature: _____

Date: _____

Appendix H

EVALUATION OF ROTATION

RESIDENT: _____ ROTATION: _____

SUPERVISOR(S): _____

TIME PERIOD: _____ DATE COMPLETED: _____

Please complete the following ratings:

Unsatisfactory/ Below Average	Satisfactory/ Average	Very Satisfactory/ Above Average	Not Applicable
	1	2	3
			na
Orientation to rotation -----	1	2	3
Organization of rotation -----	1	2	3
Early identification of goals and objectives -----	1	2	3
Clarity of goals and objectives --	1	2	3
Range of assessment opportunities -----	1	2	3
Range of intervention opportunities -----	1	2	3
Consultation opportunities -----	1	2	3
Breadth of client problems -----	1	2	3
Workload -----	1	2	3
Access to/provision of readings/ resource material -----	1	2	3
Achievement of goals -----	1	2	3
Match between expectations and experience-----	1	2	3
Reciprocity between team and Resident -----	1	2	3
Emphasis on Best Practice-----	1	2	3
Overall rating of rotation -----	1	2	3

Please comment on any item rated "Unsatisfactory/Below Average":

Positive aspects of this rotation:

Aspects of rotation needing improvement:

Additional Comments:

Thank you for your feedback.

Resident Signature _____

Date _____

Appendix I

EVALUATION OF RESIDENCY**RESIDENT:** _____ **TIME PERIOD:** _____**ROTATION 1:** _____ **SUPERVISOR:** _____**ROTATION 2:** _____ **SUPERVISOR:** _____**ROTATION 3:** _____ **SUPERVISOR:** _____**ROTATION 4:** _____ **SUPERVISOR:** _____**DATE COMPLETED:** _____-----
Please complete the following ratings:

	Unsatisfactory/ Below Average	Satisfactory/ Average	Very Satisfactory/ Above Average	Not Applicable
Application process -----1	1	2	3	na
Interview process -----1	1	2	3	na
Orientation to hospital -----1	1	2	3	na
Orientation to clinic -----1	1	2	3	na
Organization of Residency -----1	1	2	3	na
Choice of rotations -----1	1	2	3	na
Multidisciplinary team context -----1	1	2	3	na
Technical support -----1	1	2	3	na
Resources -----1	1	2	3	na
Office space/location -----1	1	2	3	na
Salary and benefits -----1	1	2	3	na
Overall work environment -----1	1	2	3	na
Grievance process -----1	1	2	3	na
Professional development opportunities -----1	1	2	3	na
Support for research activities -----1	1	2	3	na
Match between expectations and experience -----1	1	2	3	na
Overall evaluation of Residency -----1	1	2	3	na

Please comment on any item rated “Unsatisfactory/Below Average”:

Positive aspects of the Residency program:

Areas needing improvement:

Additional comments:

Thank you for your feedback.

Resident Signature _____

Date _____