DOCTORAL RESIDENCY IN CLINICAL AND COUNSELLING PSYCHOLOGY

SOUTH FRASER CHILD AND YOUTH MENTAL HEALTH

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT

DOCTORAL RESIDENCY HANDBOOK

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INTRODUCTION:

The Doctoral Residency in Clinical and Counselling Psychology will be based at three Child and Youth Mental Health sites in Surrey, Langley and Delta, British Columbia. It is designed to provide supervised training in psychology practices, including individual and group psychotherapy, clinical intake and comprehensive assessment, outreach and community development, and professional collaboration and consultation. This internship is designed to provide the comprehensive supervised experience that meets the College of Psychologists of British Columbia internship requirements. A detailed description of the residency program is provided in this document.

Residents who work with the South Fraser Child and Youth Mental Health Residency Program will gain valuable experience with diverse populations and leave well-prepared in assessment, treatment, and best practices in ethics and diverse issues. Upon completion, residents are well equipped to work alongside other disciplines to best serve the mental health needs of children and youth, and their families. The Ministry of Child and Family Development provides a wide variety of outpatient mental health and child development services to promote good mental, physical, and emotional wellbeing. We provide a range of training and supervision services to mental health professionals and students.

Child and Youth Mental Health

Child and Youth Mental Health (CYMH) is a specialized outpatient mental health service for children, adolescence (up to the age of 18 years), and their families. Child and Youth Mental Health offers services for children and adolescents who are experiencing significant distress in their daily lives as a result of psychiatric disorders or behavioral, emotional, and developmental problems (e.g., depression, anxiety, trauma, psychosis, suicidality and self-harm, OCD, eating disorders, emotional dysregulation). Child and Youth Mental Health provides an array of services, including: screening referrals, assessments, counselling, clinical consultation, psycho-educational groups, support groups, and community education.

CYMH services are provided through multidisciplinary teams. Staff typically include psychologists, clinical social workers, counsellors with master's degrees, psychiatrists, and other mental health professionals who have training and expertise in child and youth mental health. In a collaborative manner with the client and/or family, staff members provide services that include intake, screening and referral, assessment and planning, treatment, case management, and clinical consultation.

South Fraser CYMH sites are co-located with several other MCFD service streams including Child Safety Teams, Child & Youth with Support needs, Collaborative Practice, and Youth Probation. Adjacent to, and often in conjunction with, the services provided by the Fraser Region Ministry of Children and Family Development are a number of complementary programs that provide services to children and their families. These include youth outreach services, victim assistance services, and crisis services. Programs and services are also available for victims of violence and abuse. Substance abuse services are available along with services for eating disorders, special needs, and multicultural issues. As well, there are several additional resources

and services geared towards family functioning and parenting. Specialized programs delivered in collaboration with the local Health Authority may include day treatment, psychiatric crisis intervention services, early psychosis intervention, eating disorders services, and services for mental health disorders co-occurring with substance misuse or developmental disabilities. Other tertiary services include inpatient assessment for children and youth who have psychiatric presentations or primary conduct disorder.

MISSION, PHILOSOPHY, AND GOALS

Mission

To provide broad-based, science-practitioner training to Clinical and Counselling Psychology residents.

Consistent with the overall service mandate of CYMH teams, the focus of the resident training program is on the development of assessment, diagnostic, treatment planning, intervention and prevention skills. In addition, residents learn to provide consultation to other service providers both within the Ministry (such as CYMH, Child Protection, or Child and Youth with Special Needs) and in local communities. Other risk reduction, capacity building, and early intervention services may include giving presentations on mental health topics or participating on a working group to develop a new service.

Philosophy

Training is intended to solidify the resident's skills in empirically-supported assessment and treatment approaches for children, youth, and their families who are presenting with moderate – to – severe mental health disorders. Training will be provided to Psychology residents in a manner consistent with the scientific basis of Clinical and Counselling Psychology, with a focus on promoting the development of autonomous professional Psychologists. This residency program is designed to meet the standards for accreditation by the Canadian Psychological Association (CPA) and membership in the Association of Psychology Postdoctoral and Internship Centers (APPIC).

Goals

The long-term goal of CYMH is to partner with families and communities to improve mental health outcomes for children and youth in BC by:

- Providing children and their families access to a basic continuum of timely, evidence-based mental health consultation, assessment and treatment services across the province
- Ensuring services are coordinated across public health and primary care, early child development, schools, special needs, child protection and addictions services right into adult services
- Promoting evidence-based services as the standard of care, backed up by training, education and monitoring

- Providing new resources for early intervention programs dealing with serious mental illness
- Reducing children's risk of developing mental illness through means such as public education and expert involvement across sectors

Building capacity in families and communities so they are better able to prevent and mitigate potential effects of harmful factors in a child's environment

Goals of the Residency Program

The goals of the Doctoral CYMH Residency Program are to develop core competencies in the practice of psychology including:

1. Depth and breadth of clinical skills including assessment, diagnosis, treatment planning, case conceptualization, consultation, and intervention. These skills include:
    a. The ability to conduct a clinical interview, administer psychological measures, interpret assessment results, integrate assessment data with relevant material from the interview, and generate a treatment plan.
    b. The ability to integrate all assessment data in a professional manner and write reports reflecting this integrated information, in conjunction with establishing treatment plans and developing therapeutic rapport. In addition, interpret the results of assessments in a manner appropriate for client understanding.
2. Professional conduct in accordance with the professional standards of the College of Psychologists of British Columbia, Code of Ethics, as applicable in this treatment setting.
3. Knowledge of, and appreciation for individual differences, including a client's culture/ethnicity/identity and how they may influence or impact participation in the treatment process.
4. The ability to establish productive working relationships with other professionals including accepting and providing constructive feedback.
5. The ability to monitor and recognize one's professional strengths and limitations, as well as pursuing personal and professional growth in developing a professional identity.
6. The willingness to actively solicit and integrate feedback from supervisors, to be assertive in supervision, to complete assignments from the supervisor, and to participate in supervision as scheduled.

PROGRAM STRUCTURE

The Child and Youth Mental Health Residency in Clinical Psychology offers four full-time positions which last a total of 12 months. Each full-time Resident will complete 2 supervised rotations over the course of a year. A half-time residency, taking no more than 24 months to complete, will be considered under special circumstances. The program provides residents with a planned sequence of training experiences and activities, offering exposure to a variety of

problems and diverse populations. To coordinate training, the Director of Clinical Training, Dr. Rachel Nobel, as well as the primary Supervisor Dr. Chipo McNichols, secondary supervisor Dr. Kathleen Ting and supervising staff psychologists meet in a monthly Psychology Practice meeting.

The Director of Training and all primary and secondary supervisors are Registered Psychologists in good standing with the College of Psychologists of British Columbia and each supervisor has at least two years of clinical experience since their initial registration.

Typically, each resident will devote five days per week to clinical rotations, including one-half day to completing dissertation and/or research studies. This represents two concurrent rotations, three days per week at the primary site, and two days a week at the secondary site, over the course of 12 months. Rotations are designed to provide a range of training experiences that will provide interns with the breadth and depth of knowledge required to practice as an independent professional in the field of psychology. This doctoral internship will provide supervised experience in a range of activities that includes:

1. DSM-V based diagnostic assessment and integrated with psychological assessment, psychoeducation, assessment administration and report writing, research. In order to achieve the psychological assessment goals of the internship, the competency of assessment and outcome measures were established (and were also in adherence with the student contract for learning) and used as guidelines for evaluating the interns' performance:

    (a) Assessment
    Selects appropriate assessment measures, with attention to issues of reliability and validity, to answer diagnostic questions. For example, demonstrates awareness of the strengths and limitations of administration, scoring and interpretation of traditional assessment measures; obtains advanced knowledge of psychometric theory and application.

    Applies concepts of normal/abnormal behavior to case formulation and diagnosis in the context of human development and diversity. For example, utilizes systematic approaches to selection and gathering of relevant data to inform critical clinical decision-making; draws inferences across domains of information; shows an increasing ability to identify problems areas and to use concepts of differential diagnosis; writes basic psychological reports; communicate findings verbally through supervision; provides feedback to client.

    (b) Psychological intervention: DSM-V based diagnostic assessment and psychotherapy for children and families, psychoeducation, assessment administration and report writing, research, program evaluation and development, community outreach and integrated case management incorporating a trauma focused shared care approach with other community service providers to create and implement multi-disciplinary, multi modal interventions.

Formulates and conceptualizes cases and plans interventions utilizing at least one theoretical orientation. For example, formulates diagnoses; selects appropriate interventions for different problems and populations; writes case conceptualizations and treatment plans based on EBP; expands confidence in interventions as rules become guidelines; broadens selection of interventions and their planning.

Each rotation will contribute to the resident's overall training goals, as described in their application and specified in a training contract they develop with their supervisor at the beginning of each rotation. Further, these goals are reviewed at mid-point, and evaluated at its conclusion. In each rotation, the ratio of individual supervision to client-specific hours will be at least 1:4. Primary supervisors will assume clinical responsibility for clients seen by residents. The total residency hours will be a minimum of 1600, at least 30% of which will reflect direct client service.

RESIDENCY SITES AND CLINICAL ROTATIONS

The South Fraser Child and Youth Mental Health (CYMH) Residency Program is primarily based at two Child and Youth Mental Health locations in Cloverdale - Surrey, British Columbia and in Langley, British Columbia. Exposure to a variety of problems and client populations is provided. This includes exposure to different theoretical models and treatment modalities (e.g. group, individual, family) as well as different age groups and levels of severity. Residents will become familiar with the diversity of major assessment and intervention techniques in common use with children and youth and their theoretical bases.

In addition, Both the Cloverdale - Surrey location and Langley location are major regional sites providing a range of services, including individual and group therapy, psychological assessments, caregiver psychoeducational groups, child psychiatry, pediatric consultation, community resource planning, collaboration with neighbouring agencies and school district mental health professionals, and referrals to acute care settings such as Fraser Health's Surrey Memorial Adolescent Day Treatment Program, the Ministry of Child and Family Development's Maples Treatment Centre, and Fraser Health's Eating Disorder Clinic and Early Psychosis Intervention Clinic. Each rotation site is located along major bus routes and is approximately 25 minutes from Vancouver by automobile.

Cloverdale-Surrey CYMH site
15405 88 Avenue, Surrey, BC, V3R 3P5
Supervisors: Dr. Rachel Nobel, R. Psych and Dr. Brett Robinson, R. Psych

In this three-day/week rotation, residents will engage in direct clinical service through individual and group therapy for children, youth and their families, as well as conducting comprehensive psychological assessments (e.g., cognitive; personality). In addition, residents will co-facilitate psychoeducational workshops on clinical interventions (e.g., CBT; DBT) to school-district counsellors and support staff. Client-centered, trauma-informed, and culturally competent practices are used. Additional opportunities exist for program evaluation, inter-professional consultation, and/or supervision. Residents will attend weekly administrative team meetings and

case consultations. Residents will also engage in indirect services, such as case note and assessment reports, consultation with other professional, and participating in student group supervision.

Langley Child and Youth Mental Health site
Suite 120, 20434 64th Avenue, Langley BC V2Y 1N4
Supervisor: Dr. Chipo McNichols, R. Psych

In this two day/week rotation (first six months), residents will engage in outreach and community development by providing clinical supervision to (a) clinical staff at the Langley Foundry during their drop-in counselling hours, and to (b) master-level counselling and clinical psychology students engaging in the Langley CYMH student program. The Foundry offers drop-in based solution-focused brief therapy to children and youth between the ages of 12 - 24. In addition, Residents will collaborate with Fraser Health crisis-service agencies and school-district counsellors and other support staff to provide both psychoeducation and evidence-based skills training workshops. In addition, Residents will engage in direct clinical service through individual psychotherapy and extended integrated intake assessments. Indirect activities include case note and assessment report writing, consultation with other professionals, and case conceptualization and treatment planning. Residents will also participate in weekly group supervision with other residents. Specialized, inter-professional training in Emotion-Focused Family Therapy (EFFT) and Acceptance and Commitment Therapy (ACT) is also offered.

South Delta Child and Youth Mental Health site office.
220-5000 Bridge Street, Ladner, BC.
Supervisor: Dr. Kathleen Ting, R. Psych.

In this two-day/week rotation (last six months), residents will engage in direct clinical service from 0 to 19. The site accepts referrals for a variety of mental health problems including but not limited to: Anxiety, Depression, Self-Harming behaviours, Aggression (Oppositional Defiant Disorder), significant family issues, Complex Trauma. The team has access to specialized services for Eating Disorders, Early Psychosis, Sexual Abuse, Addictions, and Autism Spectrum Disorder (ASD) and other Developmental Disabilities but it can be the case that clients with these problems also have other mental disorder(s) and would become our clients. This team is small and dedicated and prioritizes weekly meetings where a variety of topics related to personal, professional and current events issues are discussed. This team also participates on a number of community tables, a notable one is our monthly interdisciplinary Community Consultation Meeting where workers from any community agency can bring up challenging cases and we will brainstorm as a community how to proceed.

SUPERVISION AND EVALUATION

Training Plan

An overall training plan will be developed collaboratively with the resident and the director of training at the beginning of the training year. The plan will outline the resident's goals for the year and how the goals will be met. The current strengths and limitations of the resident's

background, along with the career goals of the resident, will be considered when devising the training plan. In addition, the plan includes descriptions regarding client populations, types of assessments and interventions and caseload expectations. This plan will be signed by both the resident and the director of training, as well as the resident's university director of clinical training.

In addition to the overall training plan, an individual learning contract will be developed between the resident and their primary supervisor for each rotation, outlining the specific details of the rotation in regard to objectives, experiences, (e.g., assessment and/or intervention), professional expectations, and supervision.

Due Process

In addition to the learning plan, the director will review and provide the resident with information regarding due process, should issues arise during the residency. Residency programs have documented due process procedures that describe separately how programs deal with (1) concerns about resident performance, and (2) resident's concerns about training. These procedures include the steps of notice, hearing and appeal and are given to the residents at the beginning of the training period. Concerns raised by the resident should be addressed to the Primary Supervisor with appeals in accordance with the policy set out in this Handbook. Concerns raised by a supervisor should be addressed to the resident directly and follow a similar procedure for appeals. (these procedures are described on pages 13-19).

Supervision

Structure of Supervision. Consistent with Canadian Psychological Association (CPA) accreditation criteria, residents will receive a minimum of four hours per week in direct, individual supervision. Additionally, group supervision with other residents and practicum students is also available at each site. Resident supervision is provided by the primary supervisor of each rotation site, as well as other staff psychologists who have been actively licensed (certified or registered) and in good standing with the psychology regulatory body in the jurisdiction where the program exists. All psychologists have been registered for a minimum of two years immediately prior to the time the resident starts the doctoral residency.

Supplementary supervisors are accountable to the residency director regarding their supervision of the resident. These supervisors carry clinical responsibility for the cases being supervised and are identified as such (e.g., countersigning documentation or identified as a supervisor on treatment plans, or reports).

Content of Supervision. Supervision is provided with the specific intent of dealing with psychological services rendered directly by the resident. Administrative supervision and/or personal growth experiences are not included as part of the required supervision.

The supervision model used in the residency program involves a developmental approach and consists of five steps in which the resident takes on an increasing level of responsibility and autonomy over their training year:

1) Observation (resident of supervisor).

2) Joint assessment/treatment (shared responsibility for case management).

3) Observation (supervisor of resident) - the observation may involve a supervisor in the room and prepared to intervene if necessary or observing through a one-way mirror.

4) Resident solo - supervisor pre and post sessions planning and debriefing with the resident (may use audio, video or one-way mirror if necessary or appropriate).

5) Arm's length supervision - resident carries a case load and goes over each case during regularly scheduled supervision sessions.

Not all residents may begin at step one. A resident's level of training and experience will be assessed at the commencement of their training year and those with more advanced skills in specific areas may begin supervision at step two or higher. All residents are expected to have advanced to stage five by the end of their training year.

The requirements of supervisors of psychology residents are:

1. Registered psychologists provide clinical supervision of the resident to ensure that the resident complies with the legal, administrative and professional requirements of the job. When a psychologist co-signs a report with a resident, they assume legal and professional responsibility for the contents.

2. Because of the varying skills and experience levels of each resident, it is necessary to individually tailor supervision. Specific expectations of the resident are negotiated between the supervisor and the resident at the beginning of the training year.

Supervision includes:

a. At least one regular weekly meeting during which the resident and supervisor discuss cases, clinical issues, and therapy, etc. As per CPBC requirements, the resident receives a minimum of 1 hour of supervision for each four hours of client contact per week; and at least 3 hours of regularly scheduled face-to-face individual supervision and no more than 1 hour of group supervision per week.

i) For assessments the supervisor:
- reads client file
- reviews test protocols
- discusses the resident's conceptualization of the case
- reviews diagnostic issues and treatment recommendations
- reads the resident's report, then co-signs
- makes supervision notes in client files
- ensures promptness of reports

ii) For therapy the supervisor:
- may observe or co-facilitate therapy sessions
- has a weekly discussion of treatment plans
- reviews client response to treatment
- reads the resident's documentation
- makes supervision notes in client files
- ensures promptness of reports

b. Depending on the resident's needs and level of training, supervision may also involve the viewing of sessions directly or through a one-way mirror, review of audiotaped or videotaped sessions, or co-therapy.

c. Ethical issues and questions, and relevant legislation and codes/standards of practice are also discussed in supervision as they arise in the residents' clinical work.

Payment for Supervision. The terms of payment for supervision are explicit and agreed upon prior to the onset of supervision. There will be no payment for supervision, as this is provided within the context of the residency program.

Dual Relationship. Relationships between supervisors and interns are in compliance with prevailing ethical standards with regard to dual relationships. Supervision to meet the requirements of the College of Psychologists cannot be provided in the context of a professional relationship where the objectivity or competency of the supervisor is, or could reasonably be expected to be impaired because of the supervisor's present or previous familial, social, sexual, emotional, financial, supervisory, political, administrative, or legal relationship with the supervisee or a relevant person associated with or related to the supervisee. Please refer to the College of Psychologist's Code of Conduct for further clarification.

Evaluation

Supervisors will complete 2 evaluations: a mid-rotation and end-of-rotation formal evaluation for each resident. The resident will meet with their supervisor to review their progress and determine if their experience is in keeping with their overall goals for the rotation and residency. The evaluations are competency-based, and include assessment of ethics, professionalism, general clinical skills (e.g., interviewing and engagement with the client), assessment and psychotherapeutic skills, crisis management, diversity awareness and institution to practice, involvement in supervision (receiving and provision), outreach and community development, professional development, and interdisciplinary consultation and liaison. In addition, the supervisor will comment on the resident's strengths and areas for further development. If needed, a remediation plan will be developed between the supervisor, resident, and director of clinical training, such that remedies can be completed by the end of the training year.

An evaluation form is sent to each supervisor at the mid-point and end point of the residency year. Supervisors are to complete and review these evaluations with the resident prior to returning them to the Director of Residency Training. A summary of these evaluations will then be prepared by the Director and sent on to the resident's university program (both at the mid-point and end of residency).

If problems arise in the supervisory relationship at any point during the rotation these issues will be addressed first with the supervisor and the director of training and if needed, a staff psychologist who has previously served as a supervisor but is not currently sponsoring a rotation for that year.

Outside of formal evaluation periods, the residents are invited to meet as needed with the director of training and/or their supervisors to discuss their growth as a clinician, overall progress with the program, and expectations for the residency. At the end of the program, residents will be asked to formally evaluate their experience with their supervisor.

Successful completion of the residency requires the resident to complete a minimum of 1600 hours of supervised training and successfully pass all rotations. Upon completion of the training program, the resident's skill set must be considered equivalent to an entry-level psychologist. Residents will be graded as "pass" or "fail".

Didactic Training

The residency will provide at two hours per week in didactic activities which include weekly group consultation and case presentations, in service training, or participation in psychology rounds with local health authorities.

EXPECTATIONS REGARDING PSYCHOLOGY RESIDENTS

It is the goal of the South Fraser Child and Youth Mental Health Residency Program to provide the psychology resident with a clinical experience that will facilitate professional growth. The residency is a valuable learning experience that will assist the student in developing their knowledge of psychotherapeutic strategies as well as their professional identity. Residents are expected to develop an appreciation of multi-cultural issues as well as individual differences exhibited by clients. Residents are expected to increase their proficiency in the following areas: interviewing, assessment, diagnosis, case conceptualization, treatment planning, intervention, report writing, and consultation. The resident is expected to complete psychological reports and other paperwork in a timely manner. The student will be provided with guidance from the clinical supervisors regarding the type of written evaluations, reports, and notes that are acceptable. The residents will also communicate findings in a manner that non-psychologists will find useful and understandable. The resident will be assigned specific clients with whom to work. Individual and group interventions will be required, with the possibility of family interventions and therapy based on the needs of the clients.

DURATION AND STIPEND

The residency is 12 months in duration, beginning the day after Labour Day in September and continuing until the Friday prior to the Labour Day weekend of the following year. The current stipend for a full-time residency position for the current training year is: $48,770.29.

CANDIDATE ELIBILITY, APPLICATION, AND SELECTION PROCEDURES

Eligibility

We are pleased to accept applications from doctoral (PhD or PsyD) students enrolled in clinical or counselling psychology programs. Applicants from a Canadian Psychological Association (CPA) or American Psychology Association (APA) accredited doctoral program will be given preference. Consistent with the Association of Psychology Postdoctoral and Internship Centres (APPIC) guidelines, applicants will be in the final stages of their doctoral program (i.e., have completed all degree requirements except for the dissertation, have defended their dissertation, and have received approval from their program's director of training).

Residency training is subsequent to required clerkships, practica, and/or externships. It must be obtained while enrolled in a doctoral program in psychology. To be eligible for residency program, applicants must have completed a minimum of 600 hours of supervised training experience in their graduate program (with at least 300 face-to-face hours and 150 hours of supervision).

Residents are expected to have a good working knowledge of the major therapeutic techniques and strategies used with this population. Knowledge of the DSM-5 diagnostic criteria is also expected. Some knowledge of the treatment of children and adolescents is required. Training will also be provided as needed.

Applications

Interested applicants are encouraged to contact Dr. Rachel Nobel, Director of Training, by email at : Rachel.nobel@gov.bc.ca. A complete residency application includes the following:

1. Curriculum Vitae
2. Three letters of reference, one of whom is the director of clinical training for your program and two supervisors of your clinical work
3. Graduate school transcripts
4. Two-page letter of interest explaining how our residency program will fit with your career goals
5. Two sample comprehensive psychological reports – preferably one 12 and under, and one adolescent.

Selection

Selection is based on many factors, including (in no particular order):

- Academic excellence and accomplishments
- Diversity, breadth, and depth of previous assessment and intervention experience
- Clarity and organization of letter of interest
- Fit between applicant's training and interest, and the training available at our sites
- Research productivity

COMPLAINTS RESOLUTION AND APPEALS PROCEDURE

Conflict Situation

The supervision process for residents is guided by the ethical principles outlined by a Canadian Psychological Association sub-committee. Despite this informed approach to supervision, a number of issues or circumstances may lead to perceived conflict by a resident. The guidelines below are meant to offer residents a process for resolving conflicts, not addressed by informal means, in a manner that preserves their rights and access to due process.

A. Conflict with Other Staff

If there is an unresolved conflict with a staff member, who might also be acting as a mentor or secondary supervisor, the resident is expected to seek a resolution with the support of the primary supervisor and involvement of the staff member if this is appropriate and acceptable to the resident. If this approach does not address the problem to the resident's or supervisor's satisfaction, the team leader and the director of clinical training may be asked to join discussions to assist in resolving the conflict.

B. Conflict with a Supervisor

If conflicts with a supervisor occur the following steps are to be followed.

1. The resident is expected to first consult the primary supervisor and the director of clinical training when undertaking to resolve a conflict with a supervisor.

   (The steps below should only be taken if the above has not led to a resolution of the conflict. Residents are asked to document their experiences throughout this entire process).

2. If the director of clinical training is unable to resolve the conflict, he/she will forward the information on to the host team leader who will attempt to mediate the problem.

3. If the host team leader cannot resolve the matter, she/he will select a psychologist outside of the team but acceptable to both the supervisor and the resident, who will attempt to mediate the difference. If the issue is within the Ministry of Children and Family Development, this person would be the BCGEU union steward. The resident may request the presence of their ombudsperson. The mediator is to request all written materials from the resident and supervisor prior to meeting with them. The mediator's decision is considered the final team process.

4. The resident may appeal this decision to the Regional Director of Operations if all other appeal mechanisms within the residency program have been utilized.

C. Conflict with a Supervisor who is also the Director of Clinical Training or Team Leader

If conflicts arise when the resident is being supervised by the director of clinical training or a team leader, the following steps should be followed:

1. If the resident is comfortable conveying his or her concerns directly to the director of clinical training/team leader (whoever is the supervisor in question), the resident does so.

2 If the issue is still unresolved, the information is provided to either the director of clinical training or the team leader in their administrative capacity (whomever is not involved directly in the conflict) who attempts mediation. This mediator acquires all written materials from the resident and supervisor in question prior to meeting with them. The resident may request the presence of their ombudsperson at this meeting. The decision of this mediator is considered final.

3. The resident may appeal this decision to the Regional Director of Operations if all other appeal mechanisms within the team have been utilized.

Concern About Level of Performance or Behaviour

The following section outlines the steps that are necessary should the use of probation or dismissal from the program be required due to a resident's performance or behaviour. Throughout this process, it is recommended that the resident consult with his or her ombudsperson and if necessary, the College of Psychologists of British Columbia.

A. Primary Supervisor

If, after initial discussions with the resident, a primary supervisor continues to deem the resident's performance to be below expectations, or if the resident engages in questionable behaviour, the supervisor must:

1. Increase supervisory guidance; and/or
2. Re-direct the resident to other appropriate resources such as additional didactics and readings, and in some cases, individual therapy.

At this stage, no formal communication with other team members is required. However, the primary supervisor must put in writing the concerns that led to his or her discussion with the resident, any remedial actions proposed to reduce these concerns, and the timeline identified for resolution of the concerns. This information must then be kept in the resident's supervision file.

If the concerns are serious or fall outside the boundaries of the residency, the supervisor will communicate the concerns in writing to the director of clinical training. The director of clinical training will determine if the problem is of sufficient severity to forward directly to the host team leader who may then forward it directly to the appropriate ministry supervisor or manager. The Director of Clinical Training of the resident's home university is notified of the situation by the residency director of clinical training as appropriate.

Situations may arise where a resident's behaviour is of sufficient severity that the probation procedure outlined here will be pre-empted by employer policies regarding unacceptable and/or criminal behaviour.

B. Director of Clinical Training

If the concerns identified in step 'A' are not resolved within a one-month period, the primary supervisor will forward the information to the director of clinical training who will then consult with the resident and supervisor in question to assist in the remediation process. Once again, it is imperative that the remediation plans establish a very specific timeline for the attainment of goals. At this point, the resident may wish to consult with his or her ombudsperson or BCGEU union steward. The director of clinical training will keep detailed records of meetings and remediation plans.

C. Ad Hoc Review Committee

If there are concerns after Step B that persist for more than two weeks after the involvement of the director of clinical training, the information is forwarded to the host team leader who immediately organizes an ad hoc Review Committee consisting of him/herself, the resident's ombudsperson, and another staff psychologist chosen by the director of clinical training who is acceptable to both the resident and supervisor and who has not supervised the resident. Relevant parties involved in the conflict (usually includes the resident and primary supervisor) may attend the Review Committee meetings. The director of clinical training may be consulted as part of the review process.

The Committee's mandate is to review all pertinent data, to interview the resident and supervisors involved, and to make one of the following recommendations to the Residency Support Committee:

1. no action required;
2. corrective action short of probation;
3. probation for 3 months; or
4. dismissal of the resident from the program.

All corrective actions proposed, whether involving formal probation or not, are documented on all contacts. If corrective action or probation is recommended, the Review Committee will specify a timeline for reviewing progress and will schedule a follow-up meeting. If the conflict is not resolved by a general consensus, an anonymous vote is taken in which the director of clinical training, team leader, and staff psychologist vote.

The director of clinical training summarizes the Review Committee's decision in a written document and forwards the document to all relevant parties, including the resident's academic Director of Clinical Training. The resident is provided the opportunity to have their ombudsperson or a staff psychologist representative of his or her choice present at the Residency Support Committee meeting when the case is presented.

If the decision is to place the resident on probation or to dismiss the resident, the director of clinical training communicates the decision immediately to the resident and the Director of Clinical Training of the resident's home university. Minutes of the meeting are kept.

D. Probationary Review

Prior to the end of the formal probation period, the Review Committee will review the resident's progress by examining reports and conducting interviews with the resident and relevant supervisors. The committee will make one of the following recommendations: (a) removal from probation; (b) continuation of probation for an additional stipulated period; (c) dismissal from the program. If the probation period is continued, the Review Committee will specify a timeline for review of the resident's progress.

If there is a continuation of probation, towards the end of the second probation period, the Review Committee makes one of two recommendations: (a) removal from probation; or (b) dismissal from the program. If the Review Committee recommends dismissal, the director of clinical training communicates the decision to the academic Director of Training as described in step C above.

E. Appeal Procedure

An appeal of the dismissal may be made to the host team leader within one week of the Review Committee's decision. The host team leader will appoint an independent Appeals Committee that can uphold, modify, or reject the decision of the Review Committee. The Appeals Committee will be composed of a team leader from a non-residency site, a non-supervising registered staff psychologist within the resident's major area of concentration, and a non-supervising registered staff psychologist from the resident's minor area of concentration. The registered psychologists should not have been involved in the Appeals Committee.

Endorsement of the proposed membership to the Appeals Committee is obtained by the Residency Support Committee. The decision of the Appeals Committee may be appealed to the Regional Community Mental Health Manager after all appeal mechanisms within the team have been exhausted.

Termination of Employment

Should a resident behave in a manner that causes him or her to be fired from the employ in the Ministry of Children and Family Development, the residency will be terminated and a failing grade given. Likewise, if a resident leaves the residency prior to completion without an acceptable explanation, or has an unacceptable reason for an extended absence, the residency will be terminated and a failing grade given. The academic Director of Clinical Training will be notified by the residency director of clinical training.

Residents may be asked to leave the employment of the Ministry if they,

1. Commit ethical violations that pose risks to clients or create a substantial liability risk for the Ministry of Children and Family Development, or
2. Engage in clinical practice that clearly places clients at risk despite repeated feedback from supervisors and adequate opportunities to practice more clinically safe skills.

Ethical violations that place clients or the ministry at risk can include:

1. Sexual harassment, sexual exploitation, or sexual assault of clients or staff;

2. Significant dual relationships with clients;

3. Breach of confidentiality; or

4. Falsification of records.

Clinical practice that clearly places clients at risk can include:

1. Recommending treatments beyond the scope of accepted practice for psychology; or

2. Recommending choices to a client that place him or her at undue financial or health risk without a thorough review with the client of those risks (e.g., quitting school, leaving home).

If it is determined that an inappropriate behaviour is not cause for immediate dismissal, the supervisor is responsible for providing feedback regarding inappropriate clinical practice and must do so by providing a maximum of two written warnings and suggestions for corrective actions about the behaviour in question and documenting verbal warnings and suggestions with respect to the problematic behaviour.

When appropriate, opportunity to practice clinical skills will be provided by ensuring exposure to clinical cases to facilitate clinical practice, arranging feedback on the newly practiced skills, and arranging further opportunity to practice following a second round of corrective feedback about the behaviour in question.

Complaints by Others Regarding Resident Behaviour

Any concerns regarding a resident's behaviour that have been raised by people other than the resident's supervisors (e.g. clients, other staff, police) will be directed to the host team leader who will follow appropriate discipline policies.

Appeal Procedure

An appeal of the dismissal may be made to the host team leader within one week of the *Review Committee's* decision. The team leader will appoint an independent *Appeals Committee* that can uphold, modify, or reject the decision of the Review Committee. The *Appeals Committee* will be composed of a team leader from a non-residency site, a non-supervising registered staff psychologist within the resident's major area of concentration, and a non-supervising registered staff psychologist from the resident's minor area of concentration. The registered psychologists should not have been involved in the Appeals Committee.

Endorsement of the proposed membership to the *Appeals Committee* is obtained by the *Residency Support Committee*. The decision of the *Appeals Committee* may be appealed to the Regional Community Mental Health Manager after all appeal mechanisms within the team have been exhausted.

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[1] Canadian Psychological Association ((2008) *Ethical Guidelines for Supervision in Psychology: Teaching, Research, Practice and Administration* (Document prepared by the CPA Committee on Ethics Sub-Committee)

INFORMATION ON ACCREDITATION

***The South Fraser Child and Youth Mental Health Residency Program is neither Canadian Psychological Association (CPA) nor American Psychology Association (APA) accredited.**

We are in the process of applying to the Association of Psychological Postdoctoral and Internship Centers (APPIC) Match sites.

Information on accreditation by the Canadian Psychological Association is available by contacting the following office:

Registrar of Accreditation
Canadian Psychological Association
141 Laurier Avenue West, Suite 702
Ottawa, ON K1P 5J3
Phone: 613-237-2144 (extension 333) or 1-888-472-0657
Email: accreditation@cpa.ca
Website: http://www.cpa.ca/accreditation

CONTACT INFORMATION

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