SOUTH FRASER DOCTORAL RESIDENCY IN CLINICAL AND COUNSELLING PSYCHOLOGY

RESIDENCY HANDBOOK
2025-2026

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INTRODUCTION

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

Residents who work with the SFRP 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 South Fraser Region Ministry of Children and Family Development are several 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 SFRP 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 provided by the SFRP 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. Our 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. This is done in conjunction with establishing treatment plans and developing therapeutic

rapport. In addition, the ability to 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 Health and Care Professionals of British Columbia (CHCPBC), the CPA Canadian Code of Ethics for Psychologists, and the Standards of Conduct for BC Public Service employees.
3. Knowledge of, and appreciation for individual, social, and cultural diversity and how these factors may influence or impact participation in the treatment process.
4. The ability to establish productive working relationships and communicate well 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

Organization

The South Fraser Doctoral Residency Program in Clinical and Counselling Psychology (SFRP) is an organized training program that includes a planned sequence of training experiences and activities, offering exposure to a variety of problems and diverse populations of children, youth, and families. The SFRP offers full-time positions that last a total of 12 months. Each full-time Resident will complete two supervised rotations (major and minor) over the course of a year and a four-month specialty assessment.

Accountability and Director

To coordinate training, the residency has designated a Director of Training, Dr. Rosalynn Record-Lemon, who is responsible for the integrity and quality of the residency program. Dr. Record-Lemon is a Registered Psychologist in good standing in the Province of British Columbia and is a full-time staff psychologist at Child and Youth Mental Health. The Director of Training is responsible for directing and organizing the residency program and its resources, the selection of residents, monitoring and evaluating the residency program's goals and activities, and documents and maintains the resident's training records.

Additionally, the residency has a identified a training committee consisting of the Director of Training, Primary Supervisors and Practice Leads, and MCFD Leadership (E.g., Directors of Operation). This committee meets regularly to discuss and review residency matters. Finally, the SFRP supervising staff psychologists meet in a monthly Psychology Practice meeting.

Resident Cohort

The SFRP residency program has a minimum of two residents completing the program at the same time in each rotation year.

Primary Supervisors

The SFRP has at least two full time equivalent psychologists who serve as primary supervisors and are clinically responsible for the cases seen by residents at their sites. All supervisors are Registered Psychologists in good standing with the College of

Health and Care Professionals of British Columbia (CHCPBC) and each supervisor has at least two years of clinical experience since their initial registration.

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, students, and/or staff 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.

All residency supervisors are accountable to the residency Director of Training regarding their supervision of the resident. 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).

Supervisors Requirements

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.

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) - may involve a supervisor in the room (prepared to intervene if necessary) or observing through a one-way mirror.
4. Resident solo - with 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 advance to stage five by the end of their training year.

Supervision Includes:

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

   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.

   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.

2. 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 (see developmental model of supervision description above).
3. 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.

Range of Experience

Typically, each resident will devote five days per week to clinical rotations, including one day devoted to non-clinical activities including didactic seminars, program development, and protected time for completing dissertation and/or research studies. This represents two concurrent rotations, three days per week at the major rotation site, and two days a week at the minor rotation 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 psychological assessment and intervention.

Assessment

DSM-5-TR-based diagnostic assessment activities include psychoeducation, assessment administration, scoring and interpretation, report writing, and research. To achieve the psychological assessment goals of the internship, the following competency of assessment was established and used as guidelines for evaluating the interns' performance:

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.

Psychological Intervention

Psychological intervention for children and families includes psychoeducation, DSM-5-TR based diagnostic assessment and treatment planning, report writing, delivering evidence-based psychotherapy. This may also include 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. To achieve the psychological intervention goals of the internship, the following competency of assessment was established and used as guidelines for evaluating the interns' performance:

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 evidence-based practices; 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.

Training Model and Plan

The training model is based on a 'science-practitioner' approach that emphasizes the importance of evidence-based practice and the utilization of clinical methods that are supported by research.

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 of client populations, types of assessments and interventions and caseload expectations. This plan will be signed by the resident, their supervisors, and the Director of Training, as well as the resident's university Director of Training.

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

Required Client Contact

At least 30% of the resident's time is in providing direct psychological services to clients and families. This ensures the resident are sees a sufficient number of clients to reach a level of competent clinical service in the area in which they plan to practice.

Didactic Training

The residency will provide at two hours per week in didactic activities which include weekly case conferences, workshops, in service training, or participation in psychology rounds with local health authorities. Didactic activities include (but are not limited to) case conference meetings, attending formal trainings, and professional development seminars on various topics such as therapeutic consent and framing, risk assessment, cultural diversity, working with indigenous populations, trauma-focused cognitive behavioural therapy, working with LGBTQIA2S+ clients, attachment, working with multi-disciplinary teams, and family systems theory and intervention.

Timing of Residency

Residency training is subsequent to required clerkships, practica, and/or externships. It must be obtained while enrolled in a doctoral program in psychology.

Title of Trainee

The residency-level psychology trainees are referred to by the title of "Resident" to designate their trainee status.

Program Description

The SFRP has a written statement and brochure which provides a clear description of the nature of the training program, including the goals and content of the residency and clear expectations for quantity and quality of the resident's work, and is made available to prospective residents. These materials are available on the residency website at: https://www2.gov.bc.ca/gov/content/careers-myhr/job-seekers/internship-co-op-opportunities/south-fraser-residency

Due Process

In addition to the learning plan, the Director of Training will review and provide the resident with information regarding due process, should issues arise during the residency. The Residency program has 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 with 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 23-29).

Required Time

The residency is a full-time commitment over the course of one calendar year providing, at a minimum, 1600 hours of supervised experience. A half-time residency, taking no more than twenty-four months to complete, will be considered under special circumstances.

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: $58,813.56.

Expectations of Psychology Residents

It is the goal of the South Fraser Doctoral Residency in Clinical and Counselling Psychology 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 diverse 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.

Evaluation

Supervisors will complete two evaluations: a mid-term and end-of-year/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 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 Training. A summary of these evaluations will then be prepared by the Director of Training 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."

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 regarding dual relationships. Supervision to meet the requirements of the College of Health and Care Professionals of British Columbia (CHCPBC) 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 CHCPBC Code of Conduct for further clarification.

RESIDENCY SITES AND CLINICAL ROTATIONS

The South Fraser Doctoral Residency Program in Clinical and Counselling Psychology (SFRP) is primarily based at three Child and Youth Mental Health (CYMH) locations in Langley, Delta, and White Rock/South Surrey, British Columbia. At the start of the training year, each resident will be assigned a major rotation at either Langley CYMH or Delta CYMH, a minor rotation at either Langley CYMH or Delta CYMH, and a four-month speciality rotation in White Rock/South Surrey CYMH. 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.

Both the Delta and Langley sites 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 30-45 minutes from Vancouver by automobile.

Langley Child and Youth Mental Health
Suite 120, 20434 64th Avenue, Langley BC V2Y 1N4
Supervisors: Dr. Chipo McNichols, R. Psych and Dr. Rosalynn Record-Lemon, R.Psych.

In this three day/week (major rotation) or two day/week (minor 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 have the opportunity co-facilitate psychoeducational groups and workshops (e.g., CBT; DBT, EFFT). Client-centered, trauma-informed, and culturally competent practices are used. Residents will also have the opportunity to engage in outreach and community development by providing consultation to MCFD staff and community partners and clinical supervision counselling and clinical psychology students engaging in the Langley CYMH student program. Indirect activities include case note and assessment

report writing, consultation with other professionals, and case conceptualization and treatment planning. Residents will also participate in regular group supervision with other residents and practicum students. Specialized, inter-professional training in Emotion-Focused Family Therapy (EFFT) and Acceptance and Commitment Therapy (ACT) is also offered.

South and North Delta Child and Youth Mental Health
220-5000 Bridge Street, Ladner, BC.
Supervisors: Dr. Kathleen Ting, R. Psych. and Dr. Mandeep Gurm, R.Psych.

In this three day/week (major rotation) or two day/week (minor 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). The site accepts referrals for a variety of mental health problems including but not limited to anxiety, depression, self-harming behaviours, emotion dysregulation, aggression (Oppositional Defiant Disorder), family conflicts, complex developmental trauma. Several group facilitation opportunities are also available. In the past residents have helped facilitate DBT informed groups, CBT groups, parenting groups, social skills groups, and anxiety groups. The Delta team is dedicated to community building and prioritizes weekly meetings where a variety of topics related to personal, professional and current events issues are discussed. This team also participates in several community tables, a notable one being a monthly interdisciplinary Community Consultation Meeting where workers from any community agency bring up challenging cases where we all brainstorm and jointly decide on treatment plans. Supervisors at this site specialize in using an integrative and diversity-affirming approach that is informed by research, cultural background, identity-factors, and evidence-based approaches such as DBT, CBT, EFFT, attachment-based, and psychodynamic approaches.

CYMH White Rock - South Surrey
15455 Vine Avenue, White Rock, B.C.
Supervisor: Dr. Brett Robinson, R.Psych.

In this one-day/week four-month speciality assessment rotation, residents will focus on psychological assessments for children and adolescents. While all rotations will have the capacity to complete psychological assessments, this one focuses specifically on aspects of complex psychological assessment to supplement other training. Depending on clinical need and the resident's experience and interest, such assessments may include autism spectrum disorder, components of

neuropsychological testing, personality testing, and projective testing, in addition to cognitive, academic, memory, adaptive, social-emotional and behavioural testing. Residents will learn advanced case conceptualization assessment skills for complex youth, and will build and expand competency in assessment administration, scoring, interpretation, report writing, and therapeutic feedback.

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, and/or equivalent programs of study. 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 proposal, 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-TR 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. Rosalynn Record-Lemon, Director of Training, by email at : rosalynn.record-lemon@gov.bc.ca. A complete residency application includes the following:

1. Curriculum Vitae
2. Three letters of reference, including 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 twelve 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.

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 training site's Team Leader and the Director of Training may be asked to join discussions to assist in resolving the conflict.

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 their primary supervisor and the Director of 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 process).

2. If the Director of Training is unable to resolve the conflict, they will forward the information on to the training site Team Leader, who will attempt to mediate the problem.
3. If the training site Team Leader cannot resolve the matter, they 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.

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

If conflicts arise when the resident is being supervised by the Director of Training or a Team Leader, the following steps should be followed:

1. If the resident is comfortable conveying their concerns directly to the Director of 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 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 Health and Care Professionals of British Columbia (CHCPBC).

Step 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 Training. The Director of 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 Training of the resident's university is notified of the situation by the residency Director of 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.

Step B- Director of 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 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 and/or BCGEU union steward. The Director of Training will keep detailed records of meetings and remediation plans.

Step 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 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 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 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:

- No action required;
- Corrective action short of probation;
- Probation for 3 months; or
- 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 Training, Team Leader, and staff psychologist vote.

The Director of 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 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 dismiss the resident, the Director of Training communicates the decision immediately to the resident and the Director of Training of the resident's university. Minutes of the meeting are kept.

Step 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:

- Removal from probation;
- Continuation of probation for an additional stipulated period;
- 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:

- Removal from probation; or
- Dismissal from the program.

If the Review Committee recommends dismissal, the Director of Training communicates the decision to the academic Director of Training as described in step C above.

Step 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 Director of Operations after all appeal mechanisms within the team have been exhausted.

Termination of Employment

Should a resident behave in a manner that causes them to be fired from the employment 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 Training will be notified by the residency Director of 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 Doctoral Residency in Clinical and Counselling Psychology is neither Canadian Psychological Association (CPA) nor American Psychology Association (APA) accredited.

We are a provisional member of 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

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