South Island Pre-Doctoral Residency in Clinical and Counseling Psychology

Child and Youth Mental Health Services
Ministry of Children and Family Development
Province of British Columbia

Program Handbook

For questions and further information please contact:

Dr. Laurel A. Townsend, R.Psych.
Director of Clinical Training
201 - 4478 West Saanich Road
Victoria, BC V8Z 3E9
Phone: (250) 952-5073; Fax: (250) 952-4546
Email: Laurel.Townsend@gov.bc.ca

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INTRODUCTION

Victoria, British Columbia - the "City of Gardens"

We proudly and respectfully acknowledge the Lekwungen-speaking peoples, known today as the Esquimalt and Songhees Nations, and the W̱SÁNEĆ (Pauquachin, Tsartlip, Tsawout, Tseycum) peoples, on whose lands we have the privilege to live, work, and play.

Victoria, BC, known as the "city of gardens" is located on the traditional lands of Indigenous peoples who share a Coast Salish culture and language. Archaeological evidence confirms at least 4,000 years of human habitation. As Western Canada's oldest city, Victoria began in 1843 as a Hudson Bay Company trading post, named in honour of Queen Victoria. Victoria's unique character is deeply rooted in a history full of colourful people and fascinating tales. While some of the city's British colonial heritage is still in evidence, contemporary Victoria also has a distinctly Pacific Northwest flavour. Today, Victoria is best known as the capital city of British Columbia and one of the most visitor-friendly cities anywhere. This seaside city is the vacation capital of Canada and a premiere tourist spot in the Pacific Northwest. Victoria is situated on the southern tip of Vancouver Island and located in a sub-Mediterranean zone, making it the sunniest spot in the province. Greater Victoria and its outlying areas now have a population approaching 400,000, and opportunities abound for cosmopolitan dining, superb shopping, numerous outdoor recreational activities, and a full complement of cultural offerings. The city is also noted for its fine educational institutions which include the University of Victoria, Camosun College, Lester B. Pearson College of the Pacific (one of only six in the world operated by United World Colleges), and Royal Roads University. In a survey conducted by Conde Nast Traveller magazine, Victoria was judged to be one of the world's best cities, topping the list in the category of environment and ambience. In a cross-Canada survey, Victoria residents registered the greatest satisfaction with their city, which remains one of Canada's favourite places to call home.

ABOUT CHILD AND YOUTH MENTAL HEALTH IN THE PROVINCE OF B.C.

About one in eight children and youth in British Columbia experience mental health problems serious enough to interfere with their ability to be successful and productive in their family and peer relationships, schools, and community. Currently in B.C. more than 29,000 of these children and youth receive community mental health services annually – over double the number who received these services two decades ago.

According to available evidence, an estimated 12.7% of children and youth aged 4–18 years, or nearly 95,000 children in BC, will experience mental health disorders causing significant symptoms and impairment at any given time[1]. Of the children and youth experiencing mental health disorders in BC, 4% have an anxiety disorder, 5% have attention deficit hyperactivity disorder, 3% have conduct disorder, 3.5% have depression, and 2.4% have a substance use

[1] Child and youth mental health supports | BC Gov News; Mental Illnesses in Children and Youth (cmha.bc.ca); Waddell et al. (2014). *Child and Youth Mental Disorders: Prevalence and Evidence-Based Interventions*. A Research Report for the British Columbia Ministry of Children and Family Development. Children's Health Policy Centre, Simon Fraser University.

disorder (including problems with alcohol). Some of the other mental health disorders affecting children and youth include autism spectrum disorder, bipolar disorder (1%), eating disorders (1%), and schizophrenia. The impact of these disorders on the child, youth and their families is significant and may affect the course of their lives forever.

In British Columbia, a full complement of mental health supports and services for children and youth and their families and/or caregivers is provided by the Ministries of Children and Family Development and Mental Health and Addictions (MCFD, MHA), through the health authorities, specialist physicians in private practice, as well as general physicians who provide screening, assessment and intervention for some mental health problems, and referrals to services.

MCFD provides mental health services for children and their families through four provincial programs within the Ministry: community-based Child and Youth Mental Health (CYMH) teams, Maples Adolescent Treatment Centre (the Maples), Child and Youth with Special Needs (CYSN), and Youth Forensic Psychiatric Services (YFPS).

Community-based child and youth mental health teams provide prevention, early intervention, treatment and support for infants, children and youth with mental health concerns, from birth to 19 years of age, and their families. Over 70 child and youth mental health teams in the province provided specialized mental health care to close to 30,000 children and youth over the last year. This includes services provided directly by MCFD and services funded by MCFD and provided through contracted equivalent agencies and the Vancouver Coastal Health Authority in Vancouver/Richmond.

Indigenous CYMH services are delivered directly by MCFD in some geographic areas and provided through contracted agencies in other locations. These services were developed on the basis of community consultations held during implementation of the 5-year CYMH Plan, are culturally relevant and incorporate traditional approaches to healing. Indigenous children, youth and their families and communities are also linked to services provided by general CYMH teams, as needed.

Community-based CYMH teams collaborate with regional and provincial health authorities to ensure children and youth with mental health problems, and their families, receive effective and timely mental health care. This partnership is supported by the Interministerial Protocols (2013) between MCFD, the Ministry of Education, and the MHA that promote collaboration and coordination across the three systems for school age children and youth who require support from two or more of the corresponding systems.

CYMH services are provided through multidisciplinary teams. Staff typically include psychologists, clinical social workers, counsellors with masters degrees, psychiatrists, and nurses 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 treatment planning, treatment, case management, and clinical consultation.

Referral of a child or youth to CYMH can be made by the child or youth or by individuals who are directly involved with them such as family members, other agencies, or service providers. Services are voluntary and the child/youth or parent/guardian must have knowledge of the

referral and agree with it occurring prior to initiation of services requested through third-party referral from an agency or service provider.

Clients go through an initial screening and intake process that ensures mental health services are appropriate for them. If a referral is judged to be inappropriate for our services, attempts will be made to redirect or link the referring person with a more appropriate agency or health provider. Once a referral is accepted to CYMH, the child or youth's need for service is prioritized according to their level of risk and impairment.

In a collaborative manner with the client and/or family, child and youth mental health staff provide services for the client such as assessment and treatment planning, individual, parent or group intervention, and consultation with individuals involved with the client. Consultation with individuals other than the child or youth occurs after the child or youth has given "informed consent" to the sharing of information. If the child or youth is not able to consent to the sharing of information, the parent or guardian must provide consent.

Targeted community development is also a responsibility of clinicians and includes consultation and training support to other service providers (e.g. school counsellors, guardianship workers, physicians) who may be working directly with individuals who are not receiving services from CYMH.

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 timely, evidence-based mental health consultation, assessment and treatment services; promoting evidence-based services as the standard of care, backed up by training, education and monitoring; providing resources for early intervention programs; and building capacity in families and communities.

The vision of Child and Youth Mental Health Services (CYHMS) in British Columbia is healthy children and responsible families living in safe, caring and inclusive communities. This vision is supported by the following considerations: children are society’s foundation for the future and must be the primary beneficiaries of society’s resources; the family is central to the provision of care for their children; children and their families have strengths and potential; and children have unique mental health needs that are different from those of adults.

MCFD SOUTH ISLAND CHILD AND YOUTH MENTAL HEALTH SERVICES

The South Island Pre-Doctoral Residency Program is located at Saanich Child and Youth Mental Health Services, Westshore Child and Youth Mental Health Services, and Victoria Child and Youth Mental Health Services, three of the four community-based CYMH teams serving the residents of Victoria on southern Vancouver Island. A fourth team, Indigenous Child and Youth Mental Health Services, provides direct (and consultative) clinical service to Indigenous persons up to 19 years of age and their families. Residents are provided opportunities to work with Indigenous clients and families as part of their overall training plan.

Region wide services are also provided by the High Risk Services Team (suicide prevention service), the Eating Disorders Team and the Multicultural Outreach Program. The High Risk Services Team is co-located with, while the Multicultural Outreach Program is integrated into, the Saanich Child and Youth Services team. The Eating Disorders Team is co-located with the Victoria Child and Youth Services team. All of these services are a part of the Ministry of Children and Family Development and are designed to operate in an integrated way with other service providers in the community (both in-patient and outpatient) in order to offer a comprehensive system of mental health care to children, youth and their families.

The Saanich Child and Youth Mental Health Services team provide services in assessment, treatment and consultation to children and youth in the catchment area (the municipalities of Saanich, the Saanich Peninsula, and Sidney on Vancouver Island, as well as the Southern Gulf Islands). The Westshore Child and Youth Mental Health Services team provide these same services to the catchment area of the Western Communities (including Langford, Colwood, View Royal, the Highlands, Metchosin, Sooke and Port Renfrew), while the Victoria Child and Youth Mental Health Services team serve residents of the city of Victoria. The multidisciplinary teams at Saanich, Westshore and Victoria Child and Youth Mental Health consist of psychologists, social workers, community mental health nurses, counselors, part-time psychiatry and administrative support. These staff provide services to between 450 and 550 children, youth and families per year who predominantly present with anxiety, mood, adjustment and externalizing disorders.

CLINICAL TRAINING PROGRAM IN PSYCHOLOGY

The South Island Pre-Doctoral Residency Program provides residents with the opportunity for in-depth training in child and youth mental health through active clinical work, intensive supervision, small group seminars and consultations, follow through of clients during their in-patient treatment, and interaction with other health professionals. The focus is on developing the resident's clinical skills in assessment, diagnosis, treatment planning and treatment implementation. Residents also provide consultation to other service providers both on our teams and in the community. Clients at our centres are typically referred by their parents and guardians, teachers and school counselors, family physicians, pediatricians, social workers and hospital staff. Residents will be exposed to a broad range of child and youth mental health issues and problems, ranging from adjustment disorders to early onset psychosis. These conditions will be considered in the context of the biopsychosocial model and from a developmental perspective. Residents work with different supervisors and are exposed to a variety of assessment and treatment approaches during their clinical work.

Philosophy and Goals of the Residency Program

South Island residents are considered "junior colleagues" and as such are valued members of our multidisciplinary teams. Residents are directly involved in determining their training goals over the year and are active members in all team activities. Residents are given the same benefits and opportunities as all other staff in accessing program resources, attending workshops and other professional development activities, and participating in program development. All psychology staff at Saanich, Westshore and Victoria Child and Youth Mental Health participate in the

residency program by serving as supervisors, role models, and resources regarding the wide range of issues that can arise when working in community based mental health.

The South Island Doctoral Residency Program endeavors to support its residents in the achievement of eight functional competencies and five foundational competencies over the course of their training year. These core competencies are aligned with those identified by the Canadian Psychological Association as necessary for autonomous practice as a clinical psychologist who works with children, youth and families.

Foundational Competencies

1) To increase awareness, sensitivity and understanding of individual, social and cultural diversity factors and their impacts on client presentation and the selection and delivery of psychological services.

Through didactics, direct clinical experiences and supervision, residents will be provided opportunities to develop greater understanding and skill when working with diverse clients, groups and communities who represent a range of cultural and personal backgrounds and characteristics (e.g. ethnicity, religion, socio-economic status, language, cognitive functioning, race and physical ability). Residents will learn about human rights and social justice and how to address systems of oppression and discrimination.

2) To provide educational and training opportunities regarding Indigenous Peoples, including the impacts of colonialism and oppressive practices, and the integration of culturally appropriate and strengths-based approaches into CYMH services.

Through didactics, readings, consultation with community partners (e.g. culturally competent practitioners, elders), direct clinical experience and supervision, residents will broaden their awareness of the Truth and Reconciliation Commission of Canada's Calls to Action, the history and legacy of harm caused by colonialism, the many sequelae of oppressive practices (e.g. residential schools, the 60s scoop, intergenerational trauma) and Indigenous ways of knowing and concepts of wellness.

3) To support residents' acquisition and application of evidence-based knowledge and methods.

Residents will be supported in their development of professional knowledge and skills that are based on scientific methods and research evidence. This will include but not be limited to training in evidence-based assessments and interventions, as well as training that evaluates and monitors the outcomes of such practices.

4) To support each resident's development of a professional identity and professional behavior.

Residents are supported in the development of their professional identity and behavior as it relates to identifying and observing their boundaries of competence in all areas of

practice, their capacity to be self-reflective and receive feedback from others, their engagement in self-assessment (to establish goals, improve and extend their skills), their critical thinking and the development of the profession. Training in these areas may occur through didactics, consultation, direct supervision and other means, and include a focus on time management and meeting professional deadlines, collegial communication, the ability to work across settings and contexts, and inspiring trust in the profession. Managing self-care, self-monitoring one's fitness to practice and identifying any issues affecting competence are additional areas of focus.

5) To support each resident's development as it relates to interpersonal skills and communication.

Residents are supported in the development of their capacity to relate effectively and meaningfully with individuals, groups and/or communities. This includes training in the acquisition and refinement of interpersonal skills (e.g. in therapeutic relationships, interactions with the public, communication with colleagues and supervisors) and increasing their awareness and management of process issues with others.

6) To provide education and training on bias evaluation and reflective practice.

Residents are provided opportunities to explore and learn about the impacts of personal characteristics, biases, strengths, assumptions, beliefs, power and privilege upon their professional functioning through a range of training activities that may include readings, didactics, peer supervision, one on one supervision and more.

7) To provide residents with an in-depth understanding of ethics, standards, laws and policies relevant to their practice as psychologists.

The practices of psychologists in British Columbia are governed by a number of provincial and federal acts, codes, and standards. Residents are provided access to a folder on the shared network drive containing these relevant documents. Discussion of these standards and their applications in clinical practice is also incorporated into supervision and case consultations, while yearly seminars focused on the understanding and application of ethical values, ethical concepts and ethical reasoning are included in the didactics component of the residency program.

8) To provide training in interprofessional collaboration and service settings.

Residents will be provided opportunities to learn about the unique practices and contributions of their multidisciplinary team members, collaborate with colleagues and peers, build their knowledge of discipline specific issues and concepts, and develop their ability to interact with other professionals.

Functional Competencies

1) To provide residents with in-depth training in a range of integrated assessment techniques with children and youth experiencing mental health concerns.

Through their work with various supervisors and mental health staff, residents are expected to use a wide range of evidence-based assessment types and techniques, including but not limited to socioemotional, behavioral, personality, psychoeducational, diagnostic and cognitive assessments involving structured/semi-structured clinical interviews, the administration and scoring of psychometric, self, parent and teacher report measures, direct observation and other assessment approaches. Resident training in assessment will occur in the context of the foundational competencies described above.

2) To provide residents with in-depth training in empirically validated and other best practices treatment approaches and interventions aimed at reducing mental health challenges among children, youth and families.

Staff at Saanich, Westshore and Victoria Child and Youth Mental Health Services have training and expertise in a number of empirically validated and best practices treatment interventions and approaches. Residents are most likely to receive training in individual and group cognitive-behavioral therapy, interpersonal and client centered therapies, dialectical behavior therapy, as well as parenting interventions and play therapy. Exposure to additional therapies and interventions is also available (e.g. motivational interviewing, behavior therapy, family therapy, parent training. acceptance and commitment therapy, emotion focused and attachment-based approaches, child-parent relationship therapy). Residents' intervention work will also integrate the foundational competencies identified above.

3) To develop residents' consultation skills within a multidisciplinary team and with outside agencies, including schools, the health authority, and other ministry programs.

Staff at our centres are frequently involved in consultation and advocacy both within and outside of their teams. As part of their routine clinical activities, residents will be expected to provide and receive consultation services from individuals, organizations and communities in order to facilitate the best possible care for their clients (e.g. social workers, physicians, educators, psychiatry, outside agencies).

4) To provide residents with opportunities to conduct clinical case presentations, engage in research and participate in a program development or evaluation project relevant to their practice.

Residents receive training and experience informed by a scholar practitioner model. They are provided opportunities for formal and informal case presentations and consultation. Opportunities to participate in provincially-sponsored training events on evidence-based approaches (e.g. suicide prevention, CBT for anxiety, trauma-focused CBT, early childhood intervention, etc.) and didactics (e.g. program evaluation) are also provided.

Residents are expected to complete a small program development/evaluation project and present on their dissertation research and a complex case at island wide CYMH meetings over the course of the training year.

5) To provide residents with training and experience in supervision.

Our centres frequently provide practicum placements for masters and doctoral level graduate students in psychology and counseling from the University of Victoria, City University and others. Residents are provided opportunities, where appropriate and available, to gain experience in supervision through readings, didactics, supervision workshops and direct involvement in the training of these students. Opportunities to receive supervision of their supervision is also provided.

Professional Psychology Staff

The following individuals comprise the professional body of psychologists providing direct supervision, consultation, and/or monitoring and management of the Residency Training Program:

Katherine Andrews, Ph.D., Supervisor, Westshore Child and Youth Mental Health Services

Harjit Aulakh, Ph.D., Supervisor, Indigenous Child and Youth Mental Health Services

Meriel Ballard, Psy.D., R.Psych., Supervisor, Victoria Child and Youth Mental Health

Cheryl Conant, Ph.D., R.Psych., Advisor, Child and Youth Mental Health Practice Consultant

Sonia Finseth, Ph.D., R.Psych., Supervisor, South Island Eating Disorders Program

Jessica Gissi, Ph.D., R.Psych., Supervisor, South Island High Risk Services Program

Vanessa Johnson, Ph.D., R. Psych., Supervisor, Multicultural Outreach Program and Saanich Child and Youth Mental Health

Barbara Kennedy, Ph.D., R. Psych., Supervisor, Victoria Child and Youth Mental Health

Vincenza Martinovic, Ph.D., R.Psych., Supervisor, Saanich and Westshore Child and Youth Mental Health

Josh Slatkoff, Ph.D., R. Psych., Supervisor, Victoria Child and Youth Mental Health

Laurel Townsend, Ph.D., R. Psych, Director of Clinical Training & Supervisor, Saanich Child and Youth Mental Health

Katherine Vink, Ph.D., R. Psych., Supervisor, Saanich Child and Youth Mental Health

Saanich Child and Youth Mental Health Services Professional Staff

The Saanich Child and Youth Mental Health Services team currently consists of the following additional team members (in addition to the professional psychology staff listed above):

Clinical Staff: Ned Jackson, M.S.W., Team Leader
Wade Maybie, BSc.N, B.F.A, M.A., Clinician
Twila Lavender, M.A., Clinician
Jessica Lefevbre, M.A., Clinician
Tiffany Sun, M.A., Clinician
Natalie Smith, M.A., Clinician
Dr. Priya Watson, M.D., Consulting Psychiatrist
Dana Cochrane, M.A., Psychology Resident (2024/25)

Administrative Staff: Carleigh Mason, Administrative Support
Jodi Thompson, Administrative Support
Kaily Nicholas, Administrative Support
Vida Anderson-Wulff, Office Manager

Saanich CYMH

Victoria Child and Youth Mental Health Services Professional Staff

The Victoria Child and Youth Mental Health Services team currently consists of the following additional team members (in addition to the professional psychology staff listed above):

Clinical Staff: Peter Monk, M.S.W., Team Leader

Heather Watt, M.A., Clinician
Ida Diaz, M.A., Clinician
Kim Ellison, M.S.W., Clinician
Massoud Moslehi, M.Ed., Clinician
Emily Thompson, M.A., Clinician
Jacqueline Rioux, M.A., Clinician
Madison Bratty, M.S.W., Clinician
Daniel LaFleur, M.D., Consulting Psychiatrist
Kirsten Neprily, M.A., Psychology Resident (2024/25)

Administrative Staff: Vida Anderson-Wulff, Office Manager
Kristin Devone, Administrative Support
Ellie Martin, Administrative Support
Kathy Christensen, Administrative Support

Victoria CYMH

Westshore Child and Youth Mental Health Services Professional Staff

The Westshore Child and Youth Mental Health Services team currently consists of the following additional team members (in addition to the professional psychology staff listed above):

Clinical Staff: Sukkie Sihota, M.Ed., Team Leader
Kim Ajele, M.S.W., Clinician
Maria Claire Clarke, M.A., Clinician
Rebecca Wills, M.A., Clinician
Tyler Fong, M.A., Clinician

Baxter Bayer, M.A., Clinician

Sophia Hughes, M.A., Clinician

Dr. Daniel LaFleur, M.D., Consulting Psychiatrist

Devyn Colquhoun, M.A., Psychology Resident (2024/25)

Administrative Staff: Autumn Barkley, Office Manager

Daniel Brown, Administrative Support

Westshore CYMH

Policy Division Professional Staff

Kelly Angelius, M.S.W., Manager, CYMH Policy and Prevention, Early Intervention

Kelly Czmielewski, M.C., Director, CYMH Policy and Prevention, Early Intervention

RESIDENCY CHARACTERISTICS

The following criteria are in accordance with the guidelines established by the Canadian Psychological Association (as of 2023) and the College of Health and Care Providers in BC (formerly known as the College of Psychologists of British Columbia; see 2014).

1. Organization

A psychology residency is an organized training program which, in contrast to supervised experience or on-the-job training, is designed to provide the resident with a planned, programmed sequence of training experiences and activities, providing exposure to a variety of problems and populations. The primary focus and purpose is assuring breadth and quality of training.

The South Island offers a psychology residency program in community mental health that includes a broad range of experiences spanning individual, family, group and community. The range of activities includes assessment, diagnosis, treatment, consultation, ethics, case management, education, and evaluation, among others.

2. Accountability

The residency agency has a clearly designated staff psychologist ("Director of Residency Training") who is responsible for the integrity and quality of the training program and present at the training facility for a minimum of 20 hours a week. This psychologist has graduated with a doctorate from a clinical, counselling or school psychology program, and has been actively licensed (certified or registered) and in good standing with the psychology regulatory body in the jurisdiction in which the program is located for a minimum of two years immediately prior to the time the resident starts the doctoral residency.

Director of Residency Training: Laurel A. Townsend, Ph.D., R. Psych. has been a registrant of the College of Psychologists of British Columbia (#1571) since 2004. Dr. Townsend is on site four days per week. She holds a doctorate degree in clinical psychology from the University of Victoria, a CPA accredited program.

3. Director

The Director of Residency Training is an experienced and senior professional who has had prior and substantive experience in the provision of training. He/she is advised by a training committee of other psychologists who are themselves significantly involved in the residency program.

See above. Dr. Townsend has provided training and supervision to practicum students, pre-doctoral residents and psychiatry residents since 1998. Page ten above also outlines those regional CYMH psychologists who form part of the residency program on either an advisory or supervisory level.

4. Resident Cohort

The residency agency has at least two residents completing the residency at the same time.

The South Island program has one guaranteed residency position at Saanich Child and Youth Mental Health Services, one at Victoria Child and Youth Mental Health Services and one at Westshore Child and Youth Mental Health Services. Resident schedules are set in such a way to allow some overlap at each centre. Currently residents are on site together two to three out of five days per week.

5. Primary Supervisors

The residency agency training staff consists of at least two full time equivalent psychologists who serve as primary supervisors, who are doctoral prepared, have been actively licensed (certified or registered) and are in good standing with the psychology regulatory body in the jurisdiction in which

the program is located for a minimum of two years immediately prior to the time the resident starts the doctoral residency.

Primary Supervisors: *Katherine Andrews, Ph.D.*
Meriel Ballard, Psy.D., R.Psych.
Vanessa Johnson, Ph.D., R. Psych.
Barbara Kennedy, Ph.D., R. Psych.
Vincenza Martinovich, Ph.D., R.Psych.
Josh Slatkoff, Ph.D., R.Psych.
Laurel Townsend, Ph.D., R. Psych.
Katherine Vink, Ph.D., R. Psych

6. Structure of Supervision

Resident supervision is provided by staff members or qualified affiliates of the residency agency who 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). The minimum amount of supervision provided is at a ratio of one hour of supervision for each four hours of client contact per week. At least three hours per week of regularly scheduled face-to-face individual supervision are provided by psychologists who are doctoral prepared, actively licensed (certified or registered) and in good standing with the psychology regulatory body in the jurisdiction in which the program is located for a minimum of two years immediately prior to the time the resident starts the doctoral residency.

Residents meet with each supervisor weekly and following case discussions have their notes, reports, etc., regarding each client reviewed by the appropriate supervisor. Residents can expect a minimum of three hours per week of face-to-face individual supervision and one hour per week of group supervision. Residents also submit monthly logs documenting their supervision hours and the nature of this supervision to ensure they are accumulating the required hours and experiences. Resident supervisors themselves meet at least quarterly to review supervision issues, practices, etc.

7. 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.

Supervision is provided by the Primary Supervisor(s) and assisted by other staff (named above) who may assume direct responsibility for certain cases or activities.

8. Range of Experiences

The residency provides training in a range of psychological assessment and intervention activities and is not restricted to a single type. 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, parent, family) as well as different age groups and levels of severity. Residents become familiar with the diversity of major assessment and intervention techniques in common use and their theoretical bases. Experiences are designed to prepare the resident for practice in various settings including hospitals, private practice, outpatient clinics and other private and public institutions. The training is conducted directly with recipients of psychological services.

Recipients of service include children/adolescents and their families, parents, groups, schools, agencies, and other staff, either directly or in consultation. Training goals set out with residents at the commencement of their residency year involve a wide range of assessments and treatments with clients and families, using a number of theoretical orientations.

9. Training Plan

A written training plan detailing general and individualized training goals and objectives is completed at the beginning of the training year and signed by both the resident and the designated psychologist responsible for the training program. The plan includes descriptions regarding client populations, types of assessments and interventions and caseload expectations.

At the commencement of residency, the Director of Residency Training and each resident complete a written training plan outlining goals for the training year. This plan is periodically reviewed to ensure goals are being met. All supervisors also complete supervision contracts with each resident outlining roles and responsibilities, as well as goals for training with that particular supervisor.

10. Required Client Contact

At least 25-30% of the resident's time is in providing direct psychological services to patients/clients, seeing a sufficient number of clients to ensure that the resident reaches a level of competent clinical service in the area in which he or she plans to practice.

Primary Supervisors are responsible for ensuring the resident is competent in assessing and treating a wide variety of clinical problems that develop in children and adolescents of different ages, through direct contact with such clients. The goal is to establish a level of competence sufficient for independent practice in the resident's preferred areas of focus. Residents also submit monthly logs to the director of training documenting their hours and the nature of direct client contacts to ensure they are accumulating the required number of hours and a breadth of experience.

11. Didactic Component

The residency must provide at least two hours per week in didactic activities such as case conferences, seminars, workshops, in service training or grand rounds, and excluding supervision.

In addition to core didactics on ethics, supervision, and others, additional didactic activities are developed each year in keeping with the resident's interests and requirements. Residents are expected to attend weekly clinical meetings with all other team members at their host/primary site. Some examples of training and workshop opportunities available the past several years to residents have included:

CBT for Anxiety Disorders in Children and Youth
Advanced CBT for Treatment of Depression
Treatment of Self-Harm Behaviors in Adolescents
Concurrent Disorders: Mental Health and Addictions
Family Therapy
Motivational Interviewing
Narrative Therapy
Ethics in Clinical Practice
Suicide Risk Assessment
Multicultural Issues in Counseling and Therapy
Parent-Child Interaction Therapy
Early Psychosis Intervention
Dialectical Behavior Therapy
Interpersonal Therapy for Adolescents with Depression
Trauma Focused CBT

Residents are also required to make two presentations to program staff over the year. One involving their dissertation research and a second involving a full case presentation (from assessment to case conceptualization to treatment). Residents submit monthly education logs to the director of training that document their participation in all learning activities.

12. Timing of Residency

Residency training is subsequent to required clerkships, practica, and/or externships. For psychologists, it must be obtained while enrolled in a doctoral program or post-doctorate.

Our facilities strive to be flexible in adapting our program to meet the needs of the residents while also meeting the requirements set out by the College of Health and Care Professionals and CPA. However, all applicants must have completed their required coursework, practica, comprehensive exams and dissertation proposal prior to applying for residency.

13. Title of Trainee

The residency level psychology trainees have a title such as "Intern", "Resident", "Fellow," or other designation of trainee status.

Resident documentation is reviewed to ensure the above requirements are being met.

14. Program Description

The residency agency has a written statement or 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.

The brochure developed by the South Island Doctoral Residency Program is made available to prospective residents and provides a description of our training program. It is updated annually and available for viewing on the ministry web site at the following address: https://www2.gov.bc.ca/gov/content/careers-myhr/job-seekers/internship-co-op-opportunities/other-public-sector-internships

Applicants are also provided links to the programs promotional video and a facilities tour, which introduce the various sites, supervisors, and facilities we offer.

https://youtu.be/587PiCgRRmw

https://youtu.be/-2_gpEqqrpU

Residents receive a residency handbook upon their arrival in September that outlines the residency program's policies and procedures, as well as the residents training goals and expectations in more detail.

15. Due Process

Residency programs have documented due process procedures that describe separately how programs deal with concerns about resident performance, and residents' 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 (these procedures are described on pages 29-34.

Concerns raised by a resident should be addressed to the primary supervisor with appeals in accordance with the policy set out in the residency handbook.

Concerns raised by a supervisor should be addressed to the resident directly, and follow a similar procedure for appeals.

16. Required Time

The residency is a full-time commitment over the course of one calendar year or, half-time over the course of two, consecutive calendar years. The full-time and half-time experiences each provide, at a minimum, 1,600 hours of supervised experience. If a student elects for a half-time experience over two years, both years must take place at the same residency program. Therefore, programs offering half-time experiences must be prepared to accommodate the student for two consecutive years.

Resident positions are for one full year starting on the day following Labor Day in September. Most residents accrue hours above the required minimum of 1600 hours. The

stipend is currently $57,100 per annum and residents are entitled to three weeks off over the training year.

17. Evaluation

At least twice a year the residency program conducts formal written evaluations of each resident's performance.

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).

18. Dual Relationships

Relationships between supervisors and residents are in compliance with prevailing ethical standards with regard to dual relationships (as reflected in the *BC's Code of Conduct for Psychologists*). Supervision 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.

Our residency abides by the Codes of Ethics established by the College of Health and Care Providers for Psychologists in BC and the Canadian Psychological Association regarding dual relationships. Please refer to the College's Code of Conduct for further clarification.

19. Accreditation

Residencies accredited by the Canadian Psychological Association (CPA) or American Psychological Association (APA) will be deemed to have met the doctoral residency criteria.

The South Island Pre-Doctoral Residency Program has been accredited by the CPA since the 2018-2019 training year and meets all standards set out by them. The program was reaccredited in 2023 for a period of seven years.

20. Diversity

As part of the Ministry of Children and Family Development in the Province of British Columbia, the South Island Child and Youth Mental Health Residency Program adheres to the *BC Human Rights Code*, and as such is committed to employment equity and diversity in the workplace. All qualified individuals are encouraged to apply. This includes women, visible minorities, Indigenous Peoples, persons with disabilities, persons of diverse sexual orientation, gender identity or expression (LGBTQ2S+) and others who may contribute to diversity in the BC Public Service.

FACILITIES

Each South Island resident is assigned a primary training site, thus one is based out of Saanich Child and Youth Mental Health Services, another out of Victoria Child and Youth Mental Health Services, and the third out of Westshore Child and Youth Mental Health Services. Each resident spends three days per week at their primary site and two days per week at their secondary site for the course of the entire year. Exposure to the third site occurs through shared groups, didactics, regional meetings and other learning or clinical opportunities. The resident schedules are planned such that they overlap with each other a minimum of two days per week. All three centres are located on the second floor of two story buildings with elevator access. Residents are provided a private lockable office with lockable file space, bookshelves, and an iPhone with electronic voice mail. Residents also have a personal laptop computer in their office for word processing and are given an e-mail account at the beginning of the training year. Residents have access to large conference rooms, playrooms, and art therapy rooms on a booking basis, with the playrooms wired for audio and providing a one-way mirror for viewing of therapy sessions.

All sites have in-house libraries of current books and periodicals related to child and youth mental health and residents have access to an Inter-Library Loan service through the ministry. A Psychological Test Library and area with relevant professional literature (e.g. copies of Standards and Codes of Ethics) are also available at each site.

AREAS OF CONCENTRATION

South Island residents are offered core training experiences in community based mental health services for clients under 19 years of age. Through discussions with the Director of Residency Training and the primary supervisor(s), residents will select two of the options listed below as their major areas of concentration and the third as a minor area of concentration.

a. Early Childhood (ages 0-6)
b. Middle Childhood (ages 7-12)
c. Adolescence (13-19)

For example, a resident may elect to focus primarily on middle childhood and adolescence during their training year (their two major areas of concentration), thus the bulk of their caseload would comprise clients from this age span. Exposure to early childhood interventions and a small number of cases with this age group would then comprise their minor area of concentration. These core experiences (major and minor) are expected to involve 4.0 days per week for the entire training year.

Description of Core Training Experiences in Early Childhood

Supervisors: Meriel Ballard, Psy.D., R.Psych.
Barbara Kennedy, Ph.D., R.Psych.
Katherine Vink, Ph.D., R.Psych.
Harjit Aulakh, Ph.D.
Katherine Andrews, Ph.D.
Vincenza Martinovich, Ph.D., R.Psych.

Training in early childhood is intended to provide the resident with a range of assessment, intervention, and consultation skills applicable to clinical work with children between the ages of 0 and 6 and their families. Supervision will follow the developmental model. In addition to the assessment and treatment modalities described below, residents will develop experience consulting with a multi-disciplinary team and liaising with various community resources. Residents will learn to conduct comprehensive assessments, including psychometric testing, initial interviews with parents, observations of children in the community, structured observations of parents and children in the playroom, and both structured and unstructured assessment activities with children in the playroom. Opportunities to conduct developmental assessments are limited but do arise occasionally. Residents will have the opportunity to develop skills in a variety of intervention techniques, including consultations with parents, teachers, or daycares regarding behaviour management techniques, intervention that targets the parent-child relationship, such as interaction guidance with infants and toddlers, filial play therapy with pre-schoolers, and individual play therapy with children, which may involve either non-directive or directive approaches.

Description of Core Training Experiences in Middle Childhood

Supervisors: Vanessa Johnson, Ph.D., R.Psych.
Barbara Kennedy, Ph.D., R.Psych.
Katherine Vink, Ph.D., R.Psych.
Katherine Andrews, Ph.D.
Vincenza Martinovich, Ph.D., R.Psych.
Harjit Aulakh, Ph.D.

Training in middle childhood is intended to provide the resident with in depth exposure to clients aged 7-12 years who are presenting with both internalizing and externalizing disorders. Supervision will follow the developmental model. Common diagnoses with this age group include anxiety and mood disorders, as well as ADHD, oppositional defiant disorder, conduct problems, Tourette's, OCD, autism spectrum disorder and learning disabilities. Family discord is a frequent concomitant. Residents receive training in assessment and treatment using the biopsychosocial model. Residents will conduct comprehensive assessments which may include psychometric testing, interviews with parents and children, observations of parents and children, and feedback with the family and any associated community providers. A number of treatment approaches are used and may include CBT, behavioural therapy, elements of narrative therapy, family therapy, and solution focused approaches. Consultation to outside agencies (especially schools) is also provided on a regular basis and residents have the opportunity to co-lead a number of group interventions (e.g. parent support, attachment based, parent and child anxiety group program, emotion regulation). Opportunities to complete cognitive/psychoeducational assessments and provide feedback to families and schools are also available.

Description of Core Training Experiences in Adolescence

Supervisors: Meriel Ballard, Psy.D., R.Psych.
Sonia Finseth, Ph.D., R.Psych.

Vanessa Johnson, Ph.D., R.Psych.
Josh Slatkoff, Ph.D., R.Psych.
Laurel Townsend, Ph.D., R.Psych.
Katherine Vink, Ph.D., R.Psych.
Harjit Aulakh, Ph.D.
Jessica Gissi, Ph.D., R.Psych.

Residents working in this area will have the opportunity to conduct full psychological assessments (including interview, self-report instruments, case conceptualization, diagnosis, report writing and feedback) with youth aged 13-19 years who are presenting with a mental health concern. Supervision will follow the developmental model. Presenting problems typically include, but are not limited to, mood, anxiety, and trauma, as well as substance use, family and/or peer conflict, gender concerns, eating disorder, academic problems, and conduct disorder. Residents would be expected to carry a caseload of individual therapy clients and develop in-depth skills in the provision of cognitive behavioral, dialectical behavior, and interpersonal therapy to these clients. Participation in a 12-week CBT group for depression and anxiety is also available. Additional group therapy opportunities (e.g. parent support, attachment, adolescent DBT/ACT) are also available. Consultation to other team members and outside agencies (e.g. youth health clinic for high-risk youth) is routinely provided and residents may additionally have the opportunity to complete cognitive assessments with complex youth over the course of their training year.

Additional Training Opportunities

Multicultural Outreach Team (MOP)

The Multicultural Outreach Team is co-located with Saanich CYMH and provides outreach and in office support to clients where cultural barriers may impact their ability to seek and/or receive mental health services. Referrals are typically made by school counselors and other community providers, with most clients experiencing challenges with acculturation, cultural identity and navigating their home culture within Canada. Services are viewed through a culturally sensitive lens. Clients tend to bring complexities that include the family system, immigration status, cultural values and beliefs, and language barriers. Clinicians often have an advocacy role, particularly around helping clients and families find and navigate resources in the community. In addition to providing therapy, residents also have the opportunity to conduct psychological or psychoeducational assessments for a community partner. These assessments typically consider the cultural issues described above and often involve working with an interpreter when interviewing parents and caregivers.

Indigenous Child and Youth Mental Health Services (ICYMH)

While all CYMH teams across the province can provide services to Indigenous children, youth and families, the Indigenous child and youth mental health team in greater Victoria focuses on services specific to Indigenous children, youth and their families in this region. These services respect the culture, traditions and traditional healing practices of local Indigenous communities and can include work with extended family members, elders and others who support children and

youth to access their culture and traditions as a form of healing. Residents have opportunities to learn about and provide culturally safe psychoeducational assessments.

Groups

Residents are also provided opportunities to co-facilitate a range of group interventions across the age span. These include but are not limited to the following:

RAD (Reducing Anxiety & Depression)

This group is a 10-session psychoeducational, cognitive behavioural intervention for adolescents with anxiety and depression. Participants learn essential skills for managing anxiety and depression in a safe and supported environment. Topics include relaxation strategies, behavioral activation, challenging irrational and negative thoughts, using effective communication and social skills, facing your fears, and problem solving. Multiple methods of instruction are used, including presentations by the group leaders, discussions, role-playing and home practice. This treatment approach has been empirically validated for this population.

Connect

Connect is a 10-week attachment-based program to support parents and caregivers of pre-teens and teens with behavioral and emotional problems. Parents meet in small groups with two trained group leaders for 90 minutes each week. Each session provides parents with a new perspective on parent-teen relationships and adolescent development. Parents watch role-plays and try exercises that encourage more choices for responding to their teens' difficult behavior.

Circle of Security

Circle of Security is a reflective non-prescriptive parenting group for caregivers of children 0-10 years old. It runs for 7 weeks for 1.5 hours each week and can be run fully virtually. The Circle of Security Parenting program is based on decades of research about how secure parent-child relationships can be supported and strengthened. Using the COSP model trained facilitators work with caregivers to help them: learn to read the emotional needs of their children, successfully manage emotions, enhance their child's self-esteem, and honor the innate wisdom and desire for their child to be secure. This is not a psychoeducational group. The parenting model used differs from many of the parenting books available. It does not tell parents what to do but instead provides the wisdom to parent with reflection and growth – to move beyond being reactive as parents. It is suitable for most presenting challenges.

Child-Parent Relationship Therapy

CPRT is a research-based course that teaches parents/caregivers of young children how to use some of the same skills that play therapists use to help children experiencing social, emotional or behavioral problems. At the heart of CPRT is the premise that a secure parent child relationship is the essential factor for a child's wellbeing. In a supportive group environment, parents learn skills to respond more effectively to their children's emotional and behavioral needs. In turn,

children learn that they can count on their parents to reliably and consistently meet their needs for love, acceptance, safety and security.

OCD Group

OCD group is a cognitive behavioral intervention for adolescents and their caregivers. The structure involves two concurrent groups, one for youth and one for their caregivers, that involve psychoeducation, exposure with response prevention (ERP), managing obsessions, coping skills, and reducing caregiver accommodations. Youth attend 10 sessions which are delivered through a mix of virtual and in-person sessions, and caregivers attend 6 virtual sessions.

DBT for Teens

DBT for Teens is a nine session group that covers four core components of DBT: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. The goals of the group are to improve participant's relationships with others, develop their ability to cope with painful emotions and reduce their engagement in harmful behaviors. A concurrent three session parent group is also offered so caregivers can review and support the skills being learned by their teen.

Camp Brave

Camp Brave is an intensive one week program for children aged 4-9 with selective mutism. The group includes lead in sessions the week prior to prepare each child for the day camp. Children practice their brave talking and participate in fun activities with the goal of increasing their verbal participation over the week. Parents attend concurrent group sessions to learn skills that will support their child's brave talking in school, social and community settings.

Residents are also provided opportunities to participate in time limited focused training or clinical experiences in order to gain exposure to or further increase their skills in an area of high interest. These include but are not limited to:

a. Intake assessments (through Victoria CYMH)
b. School based services
c. Indigenous focused cultural experiences
d. Community intervention
e. Specialized group interventions (e.g. a body image group for teens, a family based treatment caregiver skills group, and a family supported ARFID treatment group through the Eating Disorders program)
f. High risk services (e.g. EFFT and safety planning workshops for caregivers)

Residents are provided one nonclinical day each week over the training year to attend meetings and didactics, network with other residents in the greater Victoria area, engage in exposure experiences, and complete indirect client activities, research, etc. This time ensures residents receive adequate opportunities for development of these skills and participation in team activities.

Program Development/Evaluation

The South Island program has established connections with the Policy and Prevention, and Early Intervention division of the ministry so residents have opportunities to become involved in program development and evaluation projects. These are projects that directly inform and impact the services provided to children and youth with mental health challenges in British Columbia. Some of the more recent projects residents have had opportunities to participate in have included:

- reviewing and updating the K-12 classroom materials for the Everyday Anxiety Strategies for Educators (EASE) program from a neurodiversity and Indigenous lens
- the development of a substance misuse prevention program for children and youth
- creating an evaluation framework and review of the prevention and early intervention program
- a quality assurance review of the EASE program
- an evaluation of the integrated practice clinician program

CHILD AND YOUTH STAFF BIOSKETCHES

Katherine Andrews, Ph.D.
McGill University, 2023

Clinical Interests and Activities: Katherine completed her Ph.D. in School and Applied Child Psychology at McGill University. She provides psychological assessment, treatment, and consultation to children, adolescents, and families with a wide range of emotional, behavioral, and learning concerns. Katherine's approach prioritizes building a trusting relationship with children and families. She uses evidenced-based practices best-suited for each individual's needs.

Harjit Aulakh, Ph.D.
McGill University, 2010

Clinical Interests and Activities: Provide culturally sensitive treatment for Indigenous children, youth and families using an integrative approach grounded in developmental and systems theories and guided by a bio-psycho-social framework. While my primary role is as the early childhood specialist on my team, I work with clients of all ages presenting with variable concerns including anxiety, mood and behavior disorders, trauma, grief and loss, addictions, non-suicidal self-injury, and parent training. Specific therapeutic modalities used within my integrative approach include: narrative therapy, cognitive-behavioral therapy, dialectical behavioral therapy, play therapy (filial and child directed), collaborative problem solving approaches, behavioral therapy, family therapy, and group therapy. Groups I currently facilitate include: parenting group based on the Positive Parenting Program (Triple P) for Indigenous parents, and a DBT skills and processing group aimed at reducing non-suicidal self-injury for teens and their parents.

Meriel J. Ballard, Psy.D., R.Psych.
Adler University 2021

Clinical Interests and Activities: Individual therapy for youth (13-19) presenting with a range of challenges including anxiety, depression, trauma, intergenerational trauma, OCD, suicidality and self-harm, substance use, family conflict, and navigating non-binary identities. Primary orientation to treatment is strength based, humanistic and person-centered using skills primarily from CBT, DBT, emotion focused family therapy, trauma-focused cognitive-behaviour therapy, and narrative therapy. I also work with early childhood (0-6) clients and caregivers on a range of challenges including separation, social, and generalized anxiety, selective mutism, adjustment and bereavement, aggression, and fostering attachment. Approaches with early childhood clients include filial therapy, child-directed play therapy, CBT, and attachment interventions. I have experience providing a range of groups including parenting groups such as Circle of Security and Child Parent Relational Therapy, OCD groups for parents and youth, and CBT or DBT based youth skills groups. I use a cultural, developmental, attachment, and trauma informed lens when working with clients and families. Other interests include assessment of ADHD and psychoeducational testing to aid in academic functioning and working with marginalized youth.

Cheryl Conant, Ph.D., R.Psych.
University of Waterloo, 1992

Clinical Interests and Activities: With a foundation in child development, systems theory, attachment theory, and neurological development, clinical experience has included child, youth, family, parental, and group interventions primarily based on Cognitive Behavioral Therapy models as well as skills groups, narrative approaches, reflecting teams, and CPRT (Child and Parent Relational Therapy). I have a special interest in early childhood mental health and in the impact of early trauma and attachment on development. Continuing education has focused on interventions for attachment disruptions and emotion regulation including the ARC model (Attachment, Self-Regulation and Competency) and Dialectical Behavior Therapy. I am currently studying Acceptance and Commitment Therapy (ACT) for children and youth.

Sonia Finseth, PhD, R.Psych.
University of Toronto, 2020

Clinical Interests and Activities: Individual, group, and family therapy with children (8-19) and caregivers to address a wide range of presenting concerns, including eating disorders, mood disorders, anxiety disorders, OCD, ADHD, selective mutism, trauma, suicidality, self-harm, identity exploration, relational difficulties, and adjustment issues. Treatment approach is integrative and includes the modalities of family-based treatment for eating disorders, cognitive-behaviour therapy, dialectical behaviour therapy, acceptance and commitment therapy, filial therapy, play therapy, and emotion focused family therapy. Psychological and psychoeducational assessments for school-age children and adolescents are also provided. Both assessment and treatment are approached with a humanistic, person-centered focus, and grounded in a developmental, trauma-informed, and LGBTQ2S affirming understanding of clients.

Jessica Gissi, Ph.D., R.Psych.
University of Toronto, 2021

Clinical Interests and Activities: As a member of the CYMH High-Risk Services team, Dr. Gissi provides clinical assessment and intervention services for youth (aged 10-19) who are experiencing active suicidal ideation. The emphasis of treatment is on helping youth gain insight into their difficulties, teach them strategies to help regulate their emotions, generate hope, and help them develop motivation to build a life worth living. Her treatment approach draws from several modalities, including DBT, CBT, and EFFT. Dr. Gissi works closely with caregivers to help them learn how to implement safety plans as well as how to connect with their youth when they are in crisis. Consultation is regularly provided to community partners, including schools, hospitals, and other mental health programs. Dr. Gissi also completes diagnostic assessments for youth with complex mental health needs using cognitive, achievement, personality, and social-emotional measures. She provides supervision to practicum students and psychology residents who are interested in gaining experience working with high-risk populations.

Barbara Kennedy, Ph.D., R. Psych.
University of Calgary, 2014

Clinical Interests and Activities: Provides individual and group therapy for children ages 0-19 (and their families) who present with a wide range of mental health issues, including anxiety, mood concerns, behavioral problems, social and family relational difficulties, developmental and learning concerns, trauma, and adjustment issues. Conducts psychological assessment with emphasis on social-emotional functioning and treatment planning, as well as psychoeducational assessment when relevant to client's mental health. Currently working primarily with early- and middle-childhood population, which often involves working closely with parents and collaborating with other community partners. Clinical work with adolescents includes individual therapy and group therapy. Therapeutic approach is grounded in a holistic developmental and relational-cultural understanding of client concerns. Integrative therapeutic approach includes attachment-based parent-child interventions, play-based therapies, interpersonal trauma work, CBT, and DBT.

Vanessa Johnson, Ph.D., R.Psych.
California School of Professional Psychology, 2003

Clinical Interests and Activities: Provides individual and group therapy to children and youth ages 6-19 who present with a broad range of mental health concerns varying in complexity including: problems with mood, developmental issues, trauma, and substance use. Case conceptualization is informed from a cross cultural, developmental, and multisystem perspective. Therapeutic modalities include cognitive behavioral therapy, interpersonal psychotherapy, and theraplay. Therapy focusses on the child's functioning in dyadic relationships, family relationships, and peer relationships. Provides cognitive assessments to assist clinicians with treatment planning, and educational planning. Develops and facilitates anxiety and social skills groups for children ages 7-12. This group combines a didactic or psychoeducation component with experiential learning and play. Also co-facilitates depression and anxiety groups for adolescents.

Vincenza Martinovich, Ph.D., R.Psych.
University of Alberta, 2022

Clinical Interests and Activities: Individual, group, and family therapy with children/youth (3-18) and caregivers presenting with a range of social-emotional, behavioral, and mental health challenges. I have a particular interest in providing assessment and intervention services with an early childhood population. My treatment approach is integrative and draws on play therapy, emotion-focused family therapy, cognitive behavioral therapy, solution focused therapy, and dialectical behavioral therapy. I have experience co-facilitating a range of groups, including Child-Parent Relational Therapy (CPRT), Connect Parent Group, OCD and anxiety groups, mindfulness groups, social skills and resilience groups in the school system, as well as trauma and attachment groups for young children and their caregivers. I have also worked with children and youth living with chronic health conditions, such as type 1 diabetes. My theoretical orientation is rooted in family systems and person-centered therapy, and I adopt a trauma-informed, attachment lens in my clinical work. My dissertation research focused on parenting in the context of family violence and this is another clinical interest of mine.

Josh Slatkoff, Ph.D., R.Psych
University of Victoria, 2006

Clinical Interests and Activities: Individual and group mental health treatment of youth and families; comprehensive testing-based psychological assessments; consultation to a multidisciplinary team for diagnostic clarification and treatment planning; provide parent training to manage disruptive adolescent behaviour from an attachment perspective; supervision of Ph.D. and M.A. practicum students in the University of Victoria's Clinical Psychology and Counselling Psychology programs; Interpersonal Therapy trainer for mental health clinicians across BC; provide continuing education events for family physicians on how to manage child and youth mental health in a primary care setting. Other interests include psychotherapy and assessment with adults, focusing on mood and anxiety disorders, trauma, chronic pain, vocational rehabilitation, and psychological-vocational assessments

Laurel A. Townsend, Ph.D., R.Psych
University of Victoria, 1996

Clinical Interests and Activities: Individual cognitive-behavioral therapy, interpersonal psychotherapy and dialectical behavior therapy with youth (aged 13-19 years) who present with a broad range of mental health concerns, including depression, anxiety, substance use, adjustment, trauma, OCD, and learning disorders. Additional concerns involving academic performance, identity development, eating, and peer/family relationships are also addressed in treatment. Other therapeutic modalities used include motivational interviewing and acceptance and commitment therapy. Developed and facilitate CBT/IPT focused groups for youth with anxiety and mood concerns. Other interests include cognitive assessment and use of data to aid in academic and vocational functioning, early intervention for psychosis, and the use of motivational interviewing techniques to engage and enhance change among youth. Supervision of masters and doctoral level students from a range of graduate programs in psychology and counseling is also provided.

Katherine Vink, PhD., R.Psych
University of Alberta, 2019

Clinical Interests and Activities: Provides assessment and intervention for children and adolescents ages 0-19 who present with a wide range of complex mental health concerns. She takes a bio-psycho-social approach to case-conceptualization and has a strong interest in multi-systems interventions involving children/adolescents and their caregiver(s). Dr. Vink provides individual, group, and caregiver interventions, primarily utilizing Cognitive-Behavioral Therapy and Dialectical-Behavioral Therapy approaches. She also conducts comprehensive psychological assessments for children and adolescents with developmental, academic, attentional, behavioral, social-emotional, and mental health difficulties. Dr. Vink is passionate about providing high-quality, client-centred care and has a particular interest in program development and evaluation.

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) Arms 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. When applicable, consulting psychologists from the hospitals or other community agencies have the same supervisory responsibility as the psychologists from Saanich, Victoria, and Westshore Child and Youth Mental Health Services (for any clients they are supervising at that agency).

3. 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 COPBC 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.

EVALUATION

Formal evaluations are conducted at the mid-point and end-point of the residency year. These written evaluations rate the resident's competencies in each of the eight training goals described previously, as well as the core competencies considered necessary for autonomous practice (i.e. assessment, treatment, diversity, consultation, ethical and professional behavior etc.). The minimum standard for completion of the Residency Program is achievement of expected competency in each training goal. Goals not achieved for reasons unrelated to the resident's performance (e.g. lack of referrals of a certain type) are not included in this standard. Goals not achieved must either be excused by the supervisor as not being essential to the residency or must be repeated or extended as necessary.

The evaluations also address the resident's strengths and provide suggestions regarding their future training in each of the following areas: assessment, diagnosis, treatment planning and implementation, and consultation with both child and adolescent clients. Summaries of these evaluations are prepared by the clinical training director and sent on to the resident's academic training director at each time point.

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, 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.

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 Behavior

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 behavior. 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 behavior, 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 behavior is of sufficient severity that the probation procedure outlined here will be pre-empted by employer policies regarding unacceptable and/or criminal behavior.

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 behavior 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 behavior in question and documenting verbal warnings and suggestions with respect to the problematic behavior.

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 behavior in question.

Complaints by Others Regarding Resident Behavior

Any concerns regarding a resident's behavior 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 Procedures

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)

ACCREDITATION STATUS

The South Island Pre-Doctoral Residency Program first received accreditation with the Canadian Psychological Association (CPA) during the 2018-2019 training year. The program applied for and was reaccredited in 2023 for a period of seven years. Our next self-study will be submitted in December 2029. The program is also a member of the Association of Psychology Post-Doctoral and Residency Centers (APPIC) and the Canadian Council of Professional Psychology Programs (CCPPP), and participates annually in the APPIC match. We follow all APPIC standards and guidelines. We also follow the training standards and guidelines set out by CPA.

CPA Accreditation Office
141 Laurier Avenue West, Suite 702
Ottawa, Ontario, K1P 5J3
Tel: 613-237-2144; Fax: 613-237-1674
Toll Free: 1-888-472-0657

SALARY AND BENEFITS

The salary level of residents is based on the BC Government Employees Union Master Agreement for Auxiliary employees. Residents are also provided additional financial compensation in lieu of health benefits and annual vacation (a further 6% is added to their biweekly pay). The annual wage amounts to approximately $57,100 per year. Residents can take up to three weeks off over the course of the training year.

IMPACTS OF COVID-19 PANDEMIC

Psychology staff and residents in CYMH are considered essential services and continued to perform in their roles throughout the course of the pandemic. Our regional teams were able to successfully transition to virtual services in the Spring of 2020 and continue to operate with a hybrid of onsite and online services. Staff and residents remain fully resourced with the necessary equipment, training, supervision and support/consultation with IT services to do their work in an effective manner. Some supervision and direct observation of sessions continues to be conducted through online technology however, the majority of services are again in person. If you have any specific concerns or training requests that may be impacted by Covid-19 you are advised to contact the director of clinical training to discuss these. The South Island program and CYMH services continue to monitor and follow all orders and guidelines made by the Provincial Health Officer. Residents, as is the case with all other public service staff, unless exempt, must be fully vaccinated for Covid-19.

QUALIFICATION CRITERIA FOR RESIDENCY APPLICANTS

Please note that these include both required elements as well as preferences. Applicants do not necessarily have to meet all the criteria to be considered for the residency.

General Academics

1) Required: All requirements for the doctoral degree in clinical, educational/school or counseling psychology except the dissertation must be completed. The dissertation proposal must be successfully defended prior to the November application deadline.

   Preferred: Dissertation complete or near completion by the beginning of the residency year in September.

2) Required: From a CPA accredited clinical or counseling program or its documented equivalent.

3) Required: Focus or emphasis on child or adolescent psychology.

Course Requirements

In addition to the course outline required by clinical or counseling programs generally, the following additional courses/training are considered important:

1) Required: Child/adolescent assessment course or equivalent experience.
   Graduate level developmental psychology course.

   Preferred: Additional child/adolescent assessment course or equivalent experience.

2) Required: Therapy course/experience with children/adolescents.

   Preferred: Therapy course and/or equivalent experience.

3) Required: Ethics course.

   Preferred: Broad based course that includes experience based dilemmas and scenarios.

Clinical Experience

1) Required: Minimum 600 hours of practicum experience, <u>at least half of</u> (i.e. 300 hours) which involves working with children, adolescents and families, that has been approved by your graduate program.

2) Preferred: Experience with complex cases

3) Preferred: Experience with group interventions

4) Required: <u>Minimum</u> of 10 child/adolescent assessments
   <u>Minimum</u> of 10 child/adolescent therapy cases

Citizenship and Language

1) Canadian citizens, those with landed immigrant or permanent residency status, or international students with valid Canadian Co-op Work Permits will be given preference, non-Canadian citizens will be considered subject to Immigration Canada requirements.

2) Fluency in English is required.

Criminal Records Check

The provincial government has legislated that all people who will be working with children and adolescents must undergo a criminal records check prior to commencing employment. The check is for any conviction which might make you a danger to children. The team receives no specific details of the record (these remain confidential) only that the person does or does not pass the screening. The costs of these record checks are covered by the employer.

Timetable:

Application deadline is **November 1st each year**.

Application and acceptance procedures follow the guidelines provided by the Association of Psychology Post-Doctoral and Residency Centers (APPIC). On site or telephone interviews are typically arranged for January. We will take part in APPIC's computerized matching on selection day and are listed with the National Match Service. You must fill out an application and be registered with APPIC to take part. You can also obtain information about our residency program on the CCPPP website (the Canadian Council of Professional Psychology Programs). Please note that we are now accredited by the CPA.

Note: This residency site agrees to abide by the APPIC policy that no person at this facility will solicit, accept or use any ranking-related information from any resident applicant.

Applications:

All applications are submitted through the AAPI online and to include:

1) Completed common APPIC Application for Psychology Internship (AAPI), and the "Academic Program's Verification of Internship Eligibility and Readiness". (http://www.appic.org/).

2) A cover letter describing your goals and preferred areas of major and minor concentration (e.g. mid childhood and adolescents as majors and ECI as a minor).

3) Current curriculum vitae.

4) Three letters of reference, one of which should be from either the academic Director of Training or the dissertation supervisor. Note, the program may contact referees directly to get further information.

5) Official university transcripts of your graduate record.

6) Brief dissertation abstract (can be recorded in the research section of the AAPI online).

It is the applicant's responsibility to ensure all of the above documentation is entered before the deadline of **November 1st**.

Interviews:

As per CCPPP recommendations, applicants will be notified on the first Friday in December whether or not they have been selected for an interview in January. January interviews will be conducted via video conferencing. Opportunities to meet with current residents and the DCT outside of the interview will also be provided.

Please email or address any inquiries to:

Dr. Laurel A. Townsend, Director of Residency Training
Saanich Child and Youth Mental Health Services
201 - 4478 West Saanich Road
Victoria, BC V8Z 3E9
Phone: (250) 952-5073; Fax: (250) 952-4546
Email: Laurel.Townsend@gov.bc.ca