PSYNOPSIS

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SPECIAL ISSUE

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Looking in the light or to it:

What can psychology contribute to health care innovation?

K.R. Cohen, Ph.D., CEO, CPA

Our Fall issue is devoted to innovations in health service delivery; a topic that is front of mind at every health table at which I sit representing CPA. As Co-Chair of the Health Action Lobby (HEAL), I have been representing to the Council of the Federation's (CoF) Health Care Innovation Working Group (HCIWG) http://www.councilofthefederation.ca/keyinitiatives/Healthcare.html

Those who follow Psynopsis Head Office Updates will know that CoF was created by Canada's premiers to support provinces and territories in playing leadership roles within a constructive and cooperative federal system. The Health Care Innovation Working Group was launched by CoF in January 2012 and in July 2012, it released its report: ***From Innovation to Action*** http://www.councilofthefederation.ca/pdfs/Health%20Innovation%20Report-E-WEB.pdf

As discussed in the report, the HCIWG's work is guided by the Premiers view that innovation needs to be the cornerstone of improved healthcare for Canadians. The work has three priorities

- scope of health care practitioners' practice to best meet patient need (This priority has come to be understood as team-based health care delivery models.)
- health human resources management
- the development of clinical practice guidelines across targeted conditions (hypertension, diabetic foot care)

These priorities were chosen to improve patient outcomes, address sentinel population health concerns (e.g. chronic disease, aging, health service delivery in rural and remote areas of the country) and to share innovations in these priority areas among Canadian jurisdictions. Addressing these priorities, the report made a number of recommendations to Canada's Premiers and Health Ministers.

First, is the deployment and implementation of guidelines (identified in the report) for the management of heart disease and diabetic foot ulcers. The recommendations further enjoin Premiers and Ministers of Health to engage their health provider groups to adopt the guidelines and to identify others. Second, is the uptake of models that successfully enhance access to primary care, emergency services in rural communities and homecare. Exemplars of successful models are described in the report. The third set of recommendations address health human resource management and principally focus on the development and sharing of datasets and evidence. The final recommendations target better prices for generic drugs and sustaining the work of the HCIWG.

CPA's charge to Canada's stakeholders in health is that we look to the light, not just in it, when considering the health care innovations in which the country should invest.

Although mental health or the psychological or behavioral determinants of health did not receive explicit attention in the report, exemplars of innovative practice did include psychologists among collaborative teams. Further, the communique that announced the release of the report (http://www.councilofthefederation.ca/pdfs/Jul26_Health%20Communique-FINAL.pdf) mentioned mental health among possible next priorities for model development. This resonates to what was HEAL's feedback to the HCIWG - HEAL member organizations achieved the most consensus that mental health become a next priority for the HCIWG.

As also reported in earlier issues of Psynopsis, CPA did make a submission on its own behalf relevant to the HCIWG's work on scope of practice. It can be found at http://cpa.ca/docs/file/Government%20Relations/modelsofcare.pdf In it, we detail the incidence and prevalence of mental disorders as well as their direct and associated costs to individuals, families, the workplace and the economy. The submission falls short of proposing a specific model of care but makes the following recommendations:

- Enhance accessibility of psychological services to low income Canadians
- Review and revisit the need for physician referrals for reimbursement of psychological services covered by third party insurers
- Integrate psychologists into primary care – attached to this recommendation, we outlined one such practice and its outcomes
- Integrate psychologists into emergency rooms
- Extend admitting and discharge responsibilities to psychologists for mental and behavioural health disorders
- Federal investment in an innovation fund to assist jurisdictions in developing a sustainable mental health infrastructure across Canada that will help improve access to mental health services.

The work of the HCIWG is quite granular in its focus on clinical practice and scope of practice guidelines. It has begun by adopting and promoting evidence-based guidelines for the care of common chronic conditions (i.e. hypertension, diabetic foot care). This approach, though entirely reasonable in that it starts with and expands the good and the possible when it comes to care, faces a few challenges. One of these, gleaned from the CoF HCIWG report, is that its success depends not only on buy-in from provincial and territorial governments but also on uptake from health providers. The range of health care providers and agencies who provide service to people with heart disease and to people with diabetes need to know about these models and be able and willing to implement them. Here is where the HCIWG wants to make the most of its engagement with HEAL and the organizational members it represents. Here too lies the responsibility of health care providers when it comes to innovation – success in innovation will depend on our meaningful commitment and engagement. We too need to be team players.

A second challenge, and this one very relevant to mental or behavioural health, is that by focusing on the adoption of models in use, governments risk looking for the quarter in the light. They risk promoting and expanding the best of what is done currently, rather than what might work best. With significant amounts of health care being provided in the private sector, private sector providers and models risk not making it to the table for consideration by government.

This latter challenge underscores the point that a cornerstone of health care innovation must be the review and revisit of the funding models and structures that support practice. Collaborative practice among Canada's health providers, most of whose services are not funded by public health insurance plans when provided outside of tertiary care facilities, cannot succeed in primary care without innovation to how health care services are funded. Nowhere is this truer than in mental and behavioural health where barriers to the integration of psychologists into primary care are largely economic – despite the fact that psychological interventions are among the most effective in treating the most common mental health problems faced by Canadians (i.e. depression and anxiety).

CPA's charge to Canada's stakeholders in health is that we look to the light, not just in it, when considering the health care innovations in which the country should invest. As shared at a recent national health provider summit, the science and practice of psychology guides us to keep several things in mind when we turn our minds to health care innovation:

- **Spending less now may mean spending more later**. Unprevented, untreated or poorly treated health problems affect families, the workplace, communities, as well as health systems – qualitatively and economically. For example, the cost of mental illness is estimated at $51 billion dollars annually in Canada[i].

- **Staying healthy and managing disease is determined by multiple factors**. Social, psychological and biological factors keep people well and contribute to the development and management of disease.

- **We live in variable states of health and illness**. Health promotion and illness prevention – and these often about social and behavioural factors – are as relevant to someone who is ill as they are to someone who is well.

- **Health doesn't, and arguably systems shouldn't, start and stop at the doctor's door.** We bring our health and illness with us home, to school, to work, to communities and in jail.

- **If we truly want to be evidence-based, providing the right care to the right person at the right time in the right place, then we need to make that care, that provider, that service accessible.**

The purpose of this Fall 2012 issue is to sample the good works psychological science and practice has and can bring to health care innovation. I encourage you all to talk about your good works – take them beyond professional and scientific journals and conversation. Take them to system funders and administrators, take them to government and bring them to CPA. Your good works are the data CPA needs to promote psychology's contribution to health and social policy and services. The time is now for the discipline and the profession to make a difference for Canada's health. CPA awaits its commissioned report on enhancing access to psychological services for Canadians – due in early 2013. Then, when governments ask us how we would make psychological services more accessible, we will have some answers. We will be able to propose a business model upon which the good work that fills these pages can be based.

[i] http://www.phac-aspc.gc.ca/publicat/cdic-mcbc/pdf/cdic283-eng.pdf

Comment la psychologie peut-elle contribuer à l'innovation en matière de santé?

K.R. Cohen, Ph.D., chef de la direction, SCP

Notre numéro d'automne est consacré à l'innovation dans la prestation des services de santé. C'est là un sujet qui est à l'avant-plan de tous les forums sur la santé où je siège à titre de représentante de la SCP. À titre de coprésidente du groupe d'Action santé (HEAL), j'ai fait des représentations au Groupe de travail sur l'innovation en matière de santé (GTIMS) du Conseil de la fédération (CDF) http://www.councilofthefederation.ca/keyinitiatives/Healthcare.html

Ceux d'entre vous qui lisez les Nouvelles du siège social dans Psynopsis savent que le CDF a été créé par les premiers ministres du Canada afin de soutenir les provinces et les territoires dans leurs rôles de leadership au sein d'un système fédéral constructif et coopératif. Le Groupe de travail sur l'innovation en matière de santé a été mis sur pied par le CDF en janvier 2012 et en juillet 2012, il a publié son rapport : ***De l'innovation à l'action*** http://www.conseildelafederation.ca/pdfsfrancais/Health%20Innovation%20Report-F-WEB.pdf

Comme décrit dans le rapport, le GTIMS est orienté par le point de vue des premiers ministres que l'innovation doit être la pierre d'assise de soins de santé améliorés pour les Canadiens. Le travail cible trois priorités :

- la portée de la pratique des praticiens en soins de santé pour mieux combler le besoin des patients (cette priorité est maintenant comprise comme des modèles de prestation de soins de santé en équipe)
- la gestion des ressources humaines dans le domaine de la santé
- l'élaboration de lignes directrices de pratique clinique pour des conditions de santé ciblées (hypertension, soins des pieds des diabétiques)

Ces priorités ont été choisies afin d'améliorer les résultats pour les patients, de se pencher sur les préoccupations de santé de la population sentinelle (p. ex. maladie chronique, vieillissement, prestation de services de santé dans les régions rurales et éloignées du pays) et de communiquer les innovations dans ces domaines prioritaires dans les administrations canadiennes. Pour s'attaquer à ces priorités, le rapport a formulé un certain nombre de recommandations aux premiers ministres du Canada et à leurs ministres de la Santé.

Tout d'abord, il faut commencer à déployer et mettre en œuvre les lignes directrices (définies dans le rapport) pour la gestion des maladies du cœur et les ulcères du pied des diabétiques. Les recommandations incitent aussi les premiers ministres et les ministres de la Santé à mobiliser leurs groupes de fournisseurs de soins de santé à adopter des lignes directrices et en définir d'autres. Deuxièmement, les recommandations portent sur l'adhésion aux modèles qui améliorent de manière fructueuse l'accès aux soins primaires, aux services d'urgence dans les collectivités rurales et au soin à domicile. Des exemples de modèles fructueux sont décrits dans le rapport. Le troisième groupe de recommandations porte sur la gestion des ressources humaines en santé, notamment sur la création et le partage d'ensembles de données et de faits probants. Les recommandations finales ciblent l'obtention de meilleurs prix pour les médicaments génériques et le soutien du travail du GTIMS.

Même si la santé mentale ou les déterminants psychologiques ou comportementaux de la santé n'ont pas retenu explicitement l'attention dans ce rapport, des exemples de pratiques innovatrices faisaient effectivement appel aux psychologues dans les équipes de collaboration. De plus, le communiqué qui annonçait la publication du rapport (http://www.conseildelafederation.ca/pdfsfrancais/FR-Communique_Task%20Force_Jan_17.pdf) mentionne que la santé mentale ferait probablement partie des prochaines priorités dans la création d'un modèle. Cela fait écho à la rétroaction de HEAL au GTIMS - organisations membres de HEAL qui a réalisé le plus grand consensus que la santé mentale devienne la prochaine priorité du GTIMS.

Comme je l'ai également indiqué dans des numéros antérieurs de Psynopsis, la SCP a aussi fait sa propre demande au GTIMS au sujet de la portée de la pratique. On peut trouver cet article à http://cpa.ca/docs/file/Government%20Relations/modelsofcare.pdf Dans cet article, nous décrivons l'incidence et la prévalence des troubles mentaux ainsi que leurs coûts directs et afférents pour les individus, les familles, le travail et l'économie. Cet article ne propose pas de modèle particulier de soins mais formule les recommandations suivantes :

- Améliorer l'accessibilité des services de psychologie aux Canadiens à faible revenu;
- Réviser et revoir le besoin d'aiguillages du médecin pour le remboursement des services de psychologie couverts par un assureur de tierce partie;
- Intégrer les psychologues dans les soins primaires – joint à cette recommandation, nous avons décrit une pratique semblable et ses résultats;
- Intégrer les psychologues dans les salles d'urgence;
- Accorder des responsabilités d'admission et de congé de l'hôpital aux psychologues en ce qui concerne les troubles de santé mentale et comportementaux;
- L'investissement fédéral dans un fonds d'innovation pour aider les administrations à créer une infrastructure de santé mentale durable partout au Canada qui aidera à améliorer l'accès aux services de santé mentale.

Suite à la page 8

Le travail du GTIMS est assez précis dans ses perspectives sur la pratique clinique et la portée de la pratique. On a commencé en adoptant et en faisant la promotion de lignes directrices fondées sur des données probantes pour le soin de conditions chroniques fréquentes (p. ex. hypertension, soins des pieds des diabétiques). Cette approche, même si elle est entièrement raisonnable dans le sens où elle donne de l'élan au bien et au possible en regard des soins, a tout de même des défis à relever. L'un d'entre eux, dont il est fait mention dans le rapport du GTIMS du CDF, est que son succès est tributaire non seulement du soutien des gouvernements provinciaux et territoriaux, mais aussi de la participation des fournisseurs de soins de santé. La gamme de fournisseurs et d'organismes de soins de santé qui assurent la prestation des services aux personnes atteintes de maladie du cœur ou du diabète doivent connaître ces modèles et être en mesure et disposés à les mettre en œuvre. C'est là que le GTIMS veut se mobiliser le plus avec groupe Action santé et les membres des organisations qu'il représente. C'est là aussi que se trouve la responsabilité des fournisseurs de soins de santé lorsqu'il est question d'innovation – le succès dans l'innovation est tributaire d'une mobilisation et d'un engagement significatifs. Nous devons aussi être des joueurs d'équipe.

Un deuxième défi, et celui-ci est très pertinent pour la santé mentale ou comportementale, est qu'en se concentrant sur l'adoption des modèles utilisés, les gouvernements risquent de s'y perdre. Ils risquent de promouvoir et d'étendre le mieux de ce qui est fait actuellement, plutôt que ce qui pourrait mieux fonctionner. Compte tenu de l'importance de la prestation des soins de santé dans le secteur privé, les fournisseurs du secteur privé et les modèles pourraient ne pas être débattus par le gouvernement.

Ce dernier défi fait valoir que l'innovation en matière de santé doit s'appuyer sur l'examen et la révision des modèles et des structures de financement sur lesquels repose la pratique. La pratique en collaboration entre les fournisseurs de soins de santé du Canada, dont la plupart des services ne sont pas financés par les régimes d'assurance santé publics lorsqu'ils sont dispensés à l'extérieur des installations de soins tertiaires, ne peut réussir dans les soins primaires sans l'innovation dans la façon de financer la prestation des services de soins de santé. C'est particulièrement le cas en santé mentale et comportementale où les obstacles à l'intégration des psychologues dans les soins primaires sont en grande partie économiques – malgré le fait que les interventions psychologiques se comptent parmi les plus efficaces dans le traitement des problèmes de santé mentale les plus courants auxquels doivent faire face les Canadiens (c.-à-d. la dépression et l'anxiété).

La SCP demande aux intervenants du Canada en santé de ne rien perdre de vue dans l'examen des innovations en matière de santé où le pays devrait investir. Comme nous l'avons communiqué à un sommet des fournisseurs de soins de santé national récent, la science et la pratique de la psychologie nous amènent à garder plusieurs choses à l'esprit lorsque nous nous penchons sur l'innovation en matière de santé :

- **Dépenser moins aujourd'hui pourrait signifier dépenser davantage plus tard**. Les problèmes de santé non prévenus, non traités ou incorrectement traités influencent les familles, le milieu de travail, les collectivités, ainsi que les systèmes de santé – tant du point d'un point de vue qualitatif qu'économique. Par exemple, le coût de la maladie mentale est estimé à 51 millions de dollars par année au Canada[i].

- **Rester en santé et gérer la maladie est déterminé par de nombreux facteurs**. Les facteurs sociaux, psychologiques et biologiques gardent les personnes en santé et contribuent à la naissance et à la gestion de la maladie.

- **Nous vivons dans des états variables de santé et de maladie**. La promotion de la santé et la prévention de la maladie – et ces éléments touchent souvent des facteurs sociaux et comportementaux – sont aussi pertinents pour une personne qui est malade que pour une personne bien portante.

- **La santé ne devrait pas, tout comme les systèmes, débuter et arrêter au cabinet du médecin.** Nous apportons notre santé et notre maladie avec nous à la maison, à l'école, au travail, dans les collectivités et dans les prisons.
- **Si nous voulons vraiment nous fonder sur des données probantes, la prestation du bon soin, à la bonne personne, au bon moment, au bon endroit, nous devons alors rendre ce soin, ce fournisseur et ce service accessibles.**

Le but du présent numéro d'automne 2012 est de montrer le bon travail que la science et la pratique de la psychologie a et peut apporter à l'innovation en matière de santé. Je vous encourage tous à parler de votre bon travail, en allant au-delà des revues professionnelles scientifiques et les conversations. Parlez-en aux bailleurs de fonds et aux administrateurs du système, parlez-en au gouvernement et parlez-en à la SCP. Votre bon travail est les données dont a besoin la SCP pour faire valoir la contribution de la psychologie à la santé et à la politique et aux services sociaux. Le temps est venu pour que la discipline et la profession fassent une différence dans le domaine de la santé au Canada. La SCP attend le rapport qu'elle a commandé sur l'amélioration de l'accès aux services de psychologie pour les Canadiens qui devrait être prêt au début de 2013. Ensuite, lorsque les gouvernements nous demanderont comment nous pouvons rendre les services de psychologie plus accessibles, nous aurons certaines réponses. Nous serons en mesure de proposer un modèle d'affaires sur lequel le bon travail qui est décrit dans ces pages pourra être fondé.

[i] http://www.phac-aspc.gc.ca/publicat/cdic-mcbc/pdf/cdic283-fra.pdf

CPA's 2012-13 Honorary President: Justice Edward F. Ormston

Jennifer Frain, Ph.D., CPA President

In June of 2011 at the CPA convention in Toronto I was keenly impressed by the words spoken by Justice Ted Ormston when he accepted his 2011 Humanitarian Award. He spoke clearly to the need for more access to psychological services for Canadians. I thought to myself then that I would like to hear more of what he had to say.

So when I became President I immediately thought of only one person I wanted to be Honourary President during my presidential year. Luckily Justice Ormston agreed to serve in this role!

Justice Ted Ormston has a deep compassion for persons with mental health difficulties who come into contact with the legal system and was instrumental in establishing the first Mental Health Court in Canada in Toronto. According to psychologists who have been privileged to witness Justice Ormston in action, his deep empathy, warmth and respect creates a courtroom that is a supportive, stigma free and humane. He provides a strong voice for psychological prevention and intervention services and encourages psychologists to advocate for improved services for all Canadians.

In addition to being recognized with the Humanitarian Award by CPA, Justice Ormston has been recognized by the legal and the mental health communities with many awards and recognitions. He currently works as the Chair of the Consent and Capacity Board of the Ministry of Health and Long Term Care in Ontario.

Président honoraire de la SCP 2012-2013 : Monsieur le juge Edward F. Ormston

Jennifer Frain, Ph.D., présidente de la SCP

En juin 2011, au congrès de la SCP à Toronto, j'avais été très impressionnée par les propos que tenais le juge Ted Ormston lorsqu'il a accepté le prix humanitaire de la SCP. Il parlait clairement de la nécessité d'un plus grand accès aux services de psychologie pour la population canadienne. Je me suis dit en moi-même que j'aurais aimé entendre davantage de ce qu'il avait à dire.

Ainsi lorsque je suis devenue présidente, j'ai immédiatement pensé qu'une seule personne pouvait occuper la présidence honoraire de la SCP au cours de mon mandat. La chance a voulu que le juge Ormston accepte de jouer ce rôle!

Le juge Ted Ormston a une profonde compassion pour les personnes ayant des difficultés de santé mentale qui ont affaire au système juridique, et il a joué un rôle important dans la mise sur pied du Tribunal de la santé mentale au Canada à Toronto. Selon les psychologues qui ont eu le privilège de voir le juge Ormston à l'œuvre, son empathie profonde, sa cordialité et son respect créent une salle de cour qui est positive et exempte de condamnation sociale et humaine. Il est un porte-parole très écouté de la prévention en psychologie et des services d'intervention, et il encourage les psychologues à faire des représentations pour l'amélioration des services pour toute la population canadienne.

En plus d'avoir été honoré par le prix humanitaire de la SCP, les communautés juridiques et de santé mentale lui ont décerné de nombreux prix et reconnaissances. Il préside actuellement la Commission du consentement et de la capacité du ministère de la Santé et des Soins de longue durée de l'Ontario.

Increasing access to therapist assisted internet cognitive behaviour therapy in Saskatchewan:

A description of the Online Therapy Unit for Service, Education, and Research

Nicole E. Pugh, Doctoral Student in Clinical Psychology &
Heather D. Hadjistavropoulos, Ph.D.
Department of Psychology, University of Regina

Depression and anxiety are prevalent, disabling, and undertreated conditions in Canada. Similar to many mental health problems, there is a significant gap between Canadians afflicted with these conditions and the number of funded mental health clinics (Tempier et al., 2009). In addition, while evidence suggests that cognitive behaviour therapy (CBT) is among the most empirically supported psychotherapies, CBT is not widely available, in part because of insufficient numbers of trained clinicians (Weissman et al., 2006) and that clients cannot afford the costs of treatment. Client factors also interfere with treatment accessibility including time constraints, residing in rural locations, and concerns about stigma. The integration of internet technology with the practice of psychotherapy is an innovative method for increasing accessibility and affordability of mental health treatment. Indeed, over 80% of Canadian households have internet access (Statistics Canada, 2010a), and approximately 70% of Canadians use the internet to seek health related information (Statistics Canada, 2010b).

Internet cognitive behaviour therapy (ICBT) is particularly efficacious for the treatment of depression and anxiety. A recent meta-analysis reported substantial effect sizes and short- and long- term benefits of ICBT (Andrews et al., 2010). ICBT involves presenting psycho-educational and cognitive behavioural materials over the internet (Barak, Klein, & Proudfoot, 2009). Offline exercises are also assigned to help solidify the skills and information. When compared with self-administered ICBT, therapist-assisted ICBT is superior (i.e., TAICBT; Spek et al., 2007). Despite the growing literature in TAICBT, the accessibility of this treatment modality in North America is extremely limited.

The Online Therapy Unit

With funding from a CIHR Partnership for Health System Improvement Program and the Saskatchewan Health Research Foundation, our group has been a forerunner in offering TAICBT to Saskatchewan residents. Lead by Dr. Heather Hadjistavropoulos from the University of Regina, the Online Therapy Unit for Service, Education, and Research was launched in

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Rural Linkages: Intercollaborative Practice

Judi Malone, Ph.D. & Paul Jerry, Ph.D.
Athabasca University, Alberta

What's the best way to develop and deliver services that will meet community and contextual needs? As Dr. Karen Cohen reminded us in our last edition of Psynopsis, "psychology asks the questions and helps affect change to the problems and priorities that face individuals, organizations, and societies" (p.5). For those of us within the scientist-practitioner model, we sometimes need to move between service delivery and research to design innovative approaches that will be effective. With a rural practice focus we have been leading an interdisciplinary team in Alberta that is collectively examining ideas for fostering human service delivery.

When in rural practice, psychologists are likely to work with rural health care systems and to collaborate on interdisciplinary teams. Rather than develop new collaborations based on new funding, an ideal approach in rural practice is to further develop existing community resources and to increase collaboration among local community helpers. Such interdisciplinary collaborations can assist rural psychologists to provide more effective services and reduce the isolation of rural practice.

Although there is research on rural practice and interdisciplinary collaboration, there remains little in the way of training or practice of collaborative work. We also know that interdisciplinary collaboration is often hindered by insufficient communication, professional specialization, and a poor integration of care.

These considerations provided the foundation for an Alberta-based project entitled, "Rural Linkages: Intercollaborative Practice for Safe & Healthy Communities". Based on the initial stages of participatory action research, this activity has us developing research where innovation is needed.

We are the psychologists who have been leading a diverse team of academics, professionals, researchers, and community members to explore rural human services with the goal of increasing the application of knowledge to rural professional practice by bridging some of the gaps between research and action to directly impact rural human services.

The first six months were spent building a community of those with a vested interest in rural human services. This collaborative project, funded by the Alberta Rural Development Network, has involved the mutual exchange of knowledge intended to create new knowledge and to develop and sustain long-term interactions among stakeholders in research. These include researchers, rural human service professionals, post-secondary educators, and communities themselves with a common goal to improve the services available to rural Albertans and to strengthen the rural human services infrastructure.

As research-practitioners, our role has now shifted to support the groups' movement into a more active phase. In the fall of 2012, we hosted a one-day facilitated conference to explore human services in rural Alberta and how they relate to safe and healthy communities. Participants from across the province collaborated in interactive presentations, discussions, and exploration on intercollaborative practice for safe and healthy rural communities. Sessions showcased communities, human services education, research, and professional practice in rural Alberta. Target areas included community development, health care, education, mental health and social services, and wellness.

This project has had four primary components. By leading a Steering Committee, we began by working to understand the current sociocontextual reality of human services and needs in rural Alberta. In our second and conference phase, we set out to develop a better understanding of the challenges and gaps in human services. The third phase grew out of the conference itself as we collaborated with a group of just under 100 participants to identify opportunities and ideas to foster vibrant, safe and healthy, communities. This culminated in the larger group working together to identify collaborative ways to address shortages and needs. Qualitative synthesis is forthcoming and will provide a clear sense of current needs, challenges & gaps, opportunities & ideas, & ways rural Albertans can work together to address human service needs.

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Partnering Hospital Services and Community Therapists for People with Borderline Personality Disorder:

Dialectical Behaviour Therapy 'Lite'

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Dialectical behaviour therapy (DBT) is a recognized evidence-based treatment for patients with borderline personality disorder (BPD). This article describes the development of an intervention for people with BPD through a collaboration between hospital-based and community services. This treatment program, called DBT 'Lite', is directed at getting "the right service to the right user at the right time in the right place and from the right provider," as advocated for by the Canadian Psychological Association. The CPA also advocates advancing community preventative measures and inter-professional collaborations.[1]

An established literature demonstrates that DBT is associated with significant decreases in suicidal and self-injurious behaviours, the number of and length of inpatient admissions, the use of psychotropic medications, the use of additional health care services, and in increased quality of life and symptom improvement.[2-11] It has shown benefits that continue even when treatment ends.[12] DBT has also been shown to be effective with adolescents[13] as well as other disorders that are comorbid with BPD such as depression,[13] eating disorders,[14] substance use,[6,11,16] and post-traumatic stress disorder.[17,18]

The Mental Health Program of The Ottawa Hospital (TOH) has had a DBT Program since 2005. The primary focus of the Mental Health program is related to the early identification and treatment of severe mental illness. Patients are provided treatment through emergency, inpatient and outpatient services, day hospital, and community programs such as Mobile Crisis, Shared Care, and Eating Disorders. The DBT Program began as a pilot program to address the problem of frequent use of costly emergency and inpatient services when there was little clear evidence that these services effectively treated patients with BPD. The DBT Program has historically included four components: Weekly individual therapy, weekly skills group, telephone coaching, and therapist consultation meetings. The program has been limited to patients already being served at TOH or to patients being treated by the small number of DBT-trained therapists in the community.

In March 2011, a Retreat was held in Ottawa to bring together both hospital and community clinicians currently treating patients with BPD. Historically, hospital-based outpatient programs in Ottawa for patients with personality disorders have been small and therefore difficult to access. Community-based professionals have often been hesitant to work with patients with BPD due to the inherent risks of working with chronically suicidal people and the lack of training and confidence to be effective with this population. This retreat identified an urgent need for collaboration between the hospitals and community services to increase access to evidence-based DBT care for patients with BPD, and for support from expert professionals trained in DBT.

One of the fundamental assumptions in DBT is that patients with BPD have skills deficits when it comes to regulating emotions, tolerating distress, and managing interpersonal relationships. Weekly skills training groups are paramount in DBT. Skill acquisition and practice is specifically related to decreased suicidal behaviours and anger.[19] Current research suggests that there is clinical value of DBT-like skills-based group interventions used in adjunct with 'treatment as usual' (i.e., not DBT)[20-22]. This finding is important both in terms of effectively using restricted publically funded services but also in providing services with demonstrated value to an increasing number of multi-problem patients. For example, when a 14-week emotion regulation skills group was added to treatment as usual for patients with BPD, significant reduction in self-injurious behaviours, anxiety, and depression were found, as well as an increased ability to cope with difficult emotions.[23]

In Spring of 2011 we implemented the DBT 'Lite' Program in response to the needs of patients otherwise unable to access DBT and to the needs of their treating professionals who were often isolated or overwhelmed in meeting patient needs. The referral criteria stipulated that the patient must not have had a serious suicide attempt in the last 6 months so as to align this less intensive service with illness severity. The Program also provided an entry point for young people (18+) who may otherwise become more ill before gaining access to other hospital-based care. The Program is a 21 week skills training group co-facilitated by DBT trained psychology and psychiatry staff. The Program is available to anyone with Borderline Personality Disorder in the community who meet the referral criteria and who have a therapist willing to reinforce skill acquisition and be available for crisis management. The number of hospital referrals is limited so that the Program can respond to the needs of the community and increase capacity in the treatment of BPD in the Ottawa area.

As of September 2012, we have received 71 referrals to the DBT 'Lite' Program. At present 40 patients have been assessed and 20 graduated and 8 are currently in the program. All com-

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Dialectical Behaviour Therapy

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munity providers are given a comprehensive Therapist Introduction Package that explains the program, DBT skills, and the expectation of commitment from the patient and therapist. It also includes guidance on how to help patients complete a Distress Tolerance Plan prior to beginning group. We coach patients directly about how they may increase their interpersonal effectiveness, including with their own therapists.

At this time there is only one group available with an ever-increasing demand. Program monitoring of the DBT-Lite Program is in development and will include patient focus groups, community provider questionnaire, and symptom monitoring during the program. We expect that results will support our clinical impression that the Program is not only effective at a symptom level for patients but also at a systems level in terms of an increased willingness of community therapists to treat patients with BPD. We would be interested in hearing about other similar programs in Canada.

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Rural Linkages

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The conference was structured to foster networking and to provide for knowledge transfer, but also for individuals to leave with a tangible personal or collaborative plan to fostering improved human services creatively and collectively. It closed with large group collaboration on the future direction of rural human services in Alberta, with the question posed, "where do we go from here to promote linkages, foster collaboration, and enhance rural human services".

While our continuing focus is on mutually engaging and informing research, practice, education, and communities, we are already looking forward to ideas for broader dissemination – of what we learn from this project and how we can all continue to collaborate. Psychology is ideally situated to guide innovations in rural health and social service delivery and we are looking forward to where this project continues to take us.

More information about this project can be obtained by contacting the authors.

Online Therapy

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April, 2010 (www.onlinetherapyuser.ca). Once clients are screened eligible from a telephone interview they can access CBT programs for depression, generalized anxiety, and panic. The programs are licensed from Swinburne University's National eTherapy Centre (http://www.swinburne.edu.au/lss/swinpsyche/etherapy/). The content is distributed over 12 modules and includes text, graphics, animation, audio, video, and online activities. At the beginning of each module, clients complete check-in questions and mood ratings, which are submitted to their therapist. Following each module, offline activities are completed. Outcome measures are also completed throughout the program.

To date, 42 community providers and 43 graduate students have been trained in the provision of TAICBT. The providers and students come from multiple disciplines including clinical psychology, social work, and nursing. Over 56% of those trained have delivered ICBT to clients, treating an average of three clients each. On a weekly basis the therapists are responsible for logging onto the website, tracking client progress, reviewing materials submitted by the client, and emailing clients. The therapists can determine which modules the clients have completed and how often each of the module pages was visited.

Overall, we found that Saskatchewan residents are very interested in TAICBT, with over 300 clients requesting services. About two thirds of these clients were referred by healthcare providers, while the remainder was self-referred. In total, approximately 200 Saskatchewan clients have received TAICBT and over 50% of clients completed all 12 modules offered. The average client was 42 years of age, female, and college educated. About half were married, working, taking psychotropic medication, and residing in a small city or rural area. Outcome results were promising and suggested that the three TAICBT programs benefitted clients, with clients reporting a statistically significant reduction in anxiety, depression, panic, and work and social adjustment from pre- to post-treatment. Our treatment outcomes compare to those reported for face-to-face therapy and remained significant when considering both partial and full treatment completion. Ratings of treatment satisfaction and therapeutic alliance were also very high.

Given the promising findings of the three TAICBT programs, our unit has expanded and is now offering the first TAICBT program for maternal depression (www.onlinetherapyuser.ca/mdo) and specialized TAICBT for older adults struggling with generalized anxiety. Later this fall 2012, we are launching a 5-module transdiagnostic TAICBT program for anxiety and depression along with a specialized program to assist clients after cancer care. When the numerous advantages of internet therapy are considered (e.g., all-hours access, access to evidence-based CBT, treatment at home) and the limited access to mental healthcare, online therapy will likely play an increasingly vital role in Canada's mental healthcare.

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Reference List available at http://www.cpa.ca/psynopsis

Relapse Prevention Following First Episode Psychosis

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Symptomatic recovery following first episode psychosis has become a relatively attainable goal, with 80% of clients experiencing symptom remission within the first year. There is, however, a high relapse rate within five years of the first episode. As subsequent episodes are often more severe and necessitate higher treatment dosages, preventing relapse remains a priority and a challenge. Our team wanted to address this issue by developing a relatively brief, user-friendly, and clinically relevant relapse prevention process which includes clients, families and clinicians.

A working group of clinicians from nursing, occupational therapy, recovery support, and psychology, conducted a literature review and content analysis of existing relapse prevention approaches (e.g., Early Psychosis Prevention and Intervention [EPPIC] model, Wellness Recovery Action Plan [WRAP], and the 'early warning signs' model by Birchwood) and then conducted a pilot project within our clinic. The final product of this process is the Cleghorn Relapse Prevention Plan (Cleghorn-RPP) which is produced in two forms: (1) a written two-page document and, (2) a portable computer-generated wallet version for easy access by clients.

The Cleghorn-RPP is generated in two stages with the client, clinical team, and family (when possible). The first stage involves generating a timeline of early warning signs, stressors, and triggers and 6 key areas are discussed with the client and family (if available): (1) Things the client does to stay well; (2) Stressors/triggers to try and avoid; (3) Early warning signs of relapse; (4) Things to do if symptoms return or if family/friends become worried about the client; (5) Things to do if thoughts emerge about changing/stopping medications and; (6) List of current medications. A final written two-page document is drafted with the client and family (together if available). The second stage involves the creation of a wallet-sized Cleghorn-RPP document which the client completes on the computer with assistance from clinical staff if needed.

Our team conducted a pilot project with 13 clients from the Cleghorn Program who were representative of the clinical and cultural diversity typically seen among the Cleghorn client population, and feedback was collected from clients, family and staff who participated in the Cleghorn-RPP process. Some of this feedback is summarized below.

Clients have reported using the Cleghorn-RPP when experiencing early warning signs and have then shared this information with clinicians. Family members have reported observing their loved one experiencing early warning signs and the Cleghorn-RPP was used to confirm observations and then the clinic was contacted. Moreover, clinicians are using the Cleghorn-RPP regularly to assess mental health status using the clients' own words. Overall, the Cleghorn-RPP has been found to be a useful clinical tool by all members involved in the process.

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Client Feedback	Family Feedback	Clinician Feedback
Felt comfortable with the process and found the content comprehensive	Found the process valuable and felt positive about discussing relapse/prevention	Described the Cleghorn-RPP process as clear and found the tools to be user-friendly and concrete
Especially liked the wallet document; portability of the tool provides a sense of reassurance "a plan in my pocket"	Appreciated the wallet card as something the client could have with them	Clinicians have been referring back to the Cleghorn-RPP in follow up discussions with clients
Reported feeling more confident about preventing a relapse after completing the Cleghorn-RPP process	Felt the process should be introduced early to have reassurance of a specific plan and recommended scheduled reviews; felt reassured having a clear plan	Clinicians have been using the Cleghorn-RPP to assess mental status using the client's own language, symptom history, and triggers

Telepsychology Innovations for Children's Mental Health

Jennifer Felsher, Ph.D., C.Psych, Coordinator of Telepsychology, Tele-Link Mental Health Program, The Hospital for Sick Children, Toronto

Health and mental health services have slowly become part of our rapidly evolving technology landscape. The term Telehealth or e-health is commonly used to describe any health related service that is provided remotely via technology-assisted media such as the telephone, video, or Internet. Over the last decade there has been an evolution in terms of the modalities used to deliver health services - services are no longer necessarily delivered in-person, but occur over a variety of mediums. This evolution has been spurred in part by innovations in communication technologies, the increased sophistication of health consumers in terms of their expectations for service and accessibility to services, and increased demands for service. An article written in the American Psychological Association Monitor (March, 2010) highlighted the rise of Telepsychology as one of those services, with Psychologists increasingly using telephone and email to provide counselling. The use of email among Psychologists has more than tripled between 2000 and 2008. In spite of the rise of other technologies, it appears that the use of video conferencing for Telepsychology has lagged behind.

The Hospital for Sick Children Tele-Link Mental Health Program has been providing distance Psychiatric mental health assessments, consultations, and education for the last decade, with much success and positive feedback from clients in remote regions of Northern Ontario and Aboriginal communities who otherwise would not have access to Child Psychiatrists. Based on their experience, it became clear that Psychological services, including comprehensive Psychological assessments were greatly lacking and desperately needed. Hence the development of our current program and practice.

The mandate of the Tele-Link Mental Health Program is to increase the clinical capacity of professionals working in rural children's mental health centres, thus expanding their scope of expertise and quality of service. The Telepsychology Program works closely with psychometrists from a variety of remote regions, training them or helping them upgrade their psychometry skills to ensure reliable test administration. Our role includes clinical consultation about cases, discussion about specific standardized measures or best practice in test administration and scoring, supervision, and direct clinical care.

With respect to client care, our program follows the American Psychological Association's Telepsychology guidelines and the Model Standards for Telepsychology Service developed by the Association of Canadian Psychology Regulatory Organizations to help navigate ethical and practice-related issues in using technology to deliver psychological services. After discussion with the client, a psychology referral is submitted by the case manager. The case manager reviews with the client the consent form outlining the assessment process including the limits of confidentiality, the security of the video connection, and where confidential material will be stored, which is signed by the client. This is reviewed again by psychology personnel prior to the clinical interview. To ensure the safety of the client, a professional from the referring agency is always present at the remote site. After the intake interview, a comprehensive standardized assessment battery is administered all via secure video link. During test administration, I have the same manual, stimulus books, and protocols as the psychometrist in order to follow along and score simultaneously. I have the capability to zoom in and see, for example, if the pattern of blocks during block design is correct or to observe the pencil grip of a child. While initially, some children or professionals may find the

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Reimagining a System of Mental Health Care for Children and Youth:

The Implementation of the Choice and Partnership Approach at the IWK Health Centre

Sharon Clark, PhD., Debbie Emberly, PhD,
IWK Health Centre, Halifax

Within the Canadian health care system staff shortages, increasing costs of service provision and increasing demand for services have resulted in the need for fundamental transformation in the way in which we deliver services. How do you change an existing continuum of mental health and addictions services when the demand continues to grow and the dollars continue to shrink? This is a service planning dilemma facing many clinical leaders and health care administrators across the county.

Mental Health and Addictions (MHA) at the IWK

The MHA program at the IWK Health Centre in Halifax, Nova Scotia has a dual service mandate, providing mental health and addiction services for children, youth, and their families who live within Halifax (population 360,000) and tertiary level care for those across the province of Nova Scotia (population 940,000). In the 2010-11 fiscal year 439 casual, part time and full time staff saw over 4700 children, youth and families, registering over 43,000 office, service, home and community based appointments.

In 2011, the MHA program at the IWK had reached a crisis point. Despite the recognition that half of all lifetime cases of mental illness start by age 14 and three quarters by age 24[1] and that at best, one in six Canadian children and youth who are experiencing a mental disorder actually access the services they need[2], at the IWK the waitlist for services was growing. The dilemma remained – do we provide more resources for children and youth waiting for treatment on waitlists, or eliminate the waitlist entirely? Fundamental transformation of service delivery was required to begin to address this crisis.

The Choice and Partnership Approach

After a comprehensive strategic planning process for the MHA program which highlighted many service delivery goals including improving access and reducing wait times, the Choice and Partnership Approach[3]was selected as a model of care. CAPA resonated with our desire to put the needs of families at the centre of the care we provide. It also had demonstrated success in multiple international child and adolescent mental health settings in transforming systems to improve the quality of care delivery through reducing wait times and improving access to care. CAPA, a UK-developed model (www.capa.co.uk), is a

clinical system of care delivery that employs lean thinking principles including the concepts of "demand" and "capacity" to better estimate clinical needs within a system, smooth internal service processes, and match our clinical capabilities to clinical and service needs. CAPA is a collaborative model which places the young person and their family in the centre of care, brings together demand and capacity ideas and a new approach to clinical skills and job planning. Services can then do the right things (clear working goals with the young person and family), with the right people (match clinicians with the right skills), at the right times (without internal or external waits). CAPA ensures informed consent and choice and incorporates care planning and evidence based practice[3].

Impact

We had a waitlist of 1100 children waiting for services for upwards of 20 months before their first contact, with a 30% rate of no show and cancellation. At the end of our second quarter of CAPA, on average, families had been waiting 3 months for an appointment. The wait for treatment appointments thereafter ranges from 4 weeks to 5 months. There remains significant variability across clinics as a result of staffing shortages and changes in referral patterns. However, we have significantly reduced wait times and improved access to services. We understand our treatment needs better than we did before - after the initial contact with our service, 36% of youth go on to need in-

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IWK Health Centre

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dividual treatment sessions, 35% receive therapeutic group treatments, and 14% exit our system as their treatment needs are met or they require services from other community based agencies. We are working towards a 33% exit rate as the CAPA model suggests is possible to achieve.

We have been collecting experience of service data from parents and adolescents since January 2012 when we began making changes in our service delivery to implement CAPA. To date we have had 114 adolescents and 218 parents/caregivers complete the feedback questionnaire. Overwhelmingly positive feedback has been received with over 98% responding either all/partly true or pretty/very much true to almost all of the questions indicating that they feel listened to; treated well; involved in decision making; and being offered new ideas.

"I felt like I was being listened to and like my opinion mattered" – adolescent client feedback

"The wait time for services was a lot shorter this time and that was great. It made it better. I like this new system." – parent feedback

Sustaining the Change

During the staff training provided by Dr. Ann York and Steve Kingsbury the two UK-based psychiatrists who developed CAPA, Dr. York spoke about assumptions we have made within health care "You do not *have* to have a waiting list. It can be eliminated. We need to stop talking about assessment and treatment—things we do *to* people—and talk instead about partnership and collaboration." The process of implementing CAPA has asked us as clinicians to rethink our processes of delivering care to families and in doing so, put ourselves into the shoes of the consumer.

We understand that CAPA has to become a cultural shift within our system. It has been transformative to really understand the demand for our service and then make considered decisions about how we match our clinical capacity to that demand. CAPA has provided a common language which is facilitating standardized processes between our teams and services. This helps to keep the family experience of using our services in the forefront of what we do. Accountability, fidelity, and monitoring of the impact of CAPA is also an integral component of success. Change is difficult within a large system of care, mistakes have been made and difficult lessons learned as we have implemented the new model. However, we know that returning to the status quo is not an option.

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Relapse Prevention

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Given the positive feedback from clients, families, and clinicians, ongoing use and formal evaluation of the Cleghorn-RPP is warranted. We also hope to explore the Cleghorn-RPP's use with the clients' broader circle of care (e.g., emergency crisis response teams, hospital emergency rooms, family physicians).

In summary, this new relapse prevention tool that our team has developed has proven to be a brief, clinically relevant tool for clients, families, and clinicians. For clients, the Cleghorn-RPP promotes client empowerment to self-care. For families, the tool assists in supporting the wellness of their loved ones. And for the clinical team, it serves as a brief check-up tool which incorporates the client's own words. Overall, this new tool provides a consistent, collaborative approach to addressing the important issue of relapse prevention with clients who are experiencing their first episode of psychosis.

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Telepsychology

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video unusual or uncomfortable, soon the video is forgotten and an intellectual assessment is administered as if I was in the room, while in reality I can be more than 500 kilometres away.

The on-site psychometrists and I work collaboratively and later discuss the scoring of the measures, thus, improving test reliability and efficacy. After is it complete, feedback and recommendations are provided to the family and case managers via video. The local staff will ultimately be responsible for providing treatment and/or bring recommendations from the psychological assessment to life.

In addition to clinical service provision, we have the capability to hold psychology team meetings whereby psychometrists from 3 different remote regions in Ontario (each several hundred kilometres apart) all take part in a clinical meeting with program staff in downtown Toronto. These psychometrists have appreciated the opportunity to meet as a team, to reduce their professional isolation, and enhance their professional development. We also share the assessment library across sites to meet the unique needs of the clients who may benefit from specialized measures.

Advances in technology have allowed us to broaden the reach of professional care to people who would not otherwise have access to Psychological services. As the cost of such equipment decreases, it becomes cost effective to use this advanced technology rather than flying a professional to a rural location for face-to-face services. Currently, the Tele-Link Mental Health Program is among the first to create and adopt a model for Telepsychology providing comprehensive assessments from a distance. Most of the Telepsychology literature refers to psychology's role in providing counseling services. To our knowledge, we are at the forefront of providing comprehensive standardized psychological assessments.

A Positive Psychology Approach to Education for At-Risk High School Youth

Sophia Fanourgiakis, Ph.D. student and Margaret Lumley, Ph.D., C.Psych., University of Guelph

Youth who fail to complete high school are more likely to struggle with ongoing unemployment and lower salaries as well as poorer emotional and behavioural outcomes[1]. A number of issues are associated with the failure to complete school, including individual, family, economic, community and school factors[2]. Youth with complex emotional, social, and learning needs not met in traditional high school settings, often experience significant struggle with their mental health and wellbeing, peer relationships, and home/family life, putting them at increased risk of school dropout and other negative outcomes.

Youth with such complex needs tend to fall between the cracks in the education system without access to appropriate services. Envisioned to serve such students, St. John Bosco (SJB) is an innovative alternative secondary school within the Wellington Catholic District School Board in Guelph, Ontario. SJB seeks to help youth overcome personal and systemic barriers to success by cultivating hope and supporting the pursuit of emotional wellbeing and positive academic outcomes. Central to the SJB program is the application of positive psychology constructs including an emphasis on student strengths and building positive relationships among staff and students to promote school engagement.

From its conception, SJB administration has recognized the importance of research-informed practice and rigorous program evaluation. SJB's current principal and visionary is educator Eileen Clinton who has consulted and collaborated with academic researchers about school development. These collaborations have included psychologist researchers; notably Drs. Margaret Lumley (Guelph), Edward Rawana (Lakehead), Jennine Rawana (York), and PhD student Sophia Fanourgiakis (Guelph) who all share great interest in identifying and promoting youth strengths through positive emotional development school engagement.

In many cases, when the youth whom SJB serve have received service in the past, these have been aimed at correcting or preventing emotional, behavioural and academic difficulties. By contrast, SJB uses a strength-based approach to working with youth, largely informed by research conducted in the field of positive psychology including the positive youth development (PYD) perspective[3]. From the PYD perspective, all youth are seen as "resources to be developed" rather than "broken" and "in need of psychological repair" [3]. The PYD framework emphasizes a systems view supporting growth and development

of the person in interaction with the context in which he or she lives in a way that benefits both[3]. Individual strengths have been defined as "a set of personal competencies and characteristics of the child or adolescent that were developed and embedded in culture and valued by both the individual and by society" [4].

SJB adopts this strength-based approach to understanding, supporting, and working with their students, right from first contact. During the referral process, students and family members are asked to identify the student's strengths and goals. Each student at SJB receives individual programming and scheduling to assist in the development of strengths and support unique social, emotional, and academic needs. Students are also encouraged to engage in classroom projects and initiatives that

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Transdiagnostic Group Cognitive-Behavioral Therapy: An Efficacious and Cost-Effective Method Across Diverse Populations

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Cognitive-behavioral therapy (CBT) is a recommended treatment for anxiety and depression[1,2] that is both efficacious[3] and cost effective[4,5]. However, only a minority of patients suffering from disorders for which CBT is recommended receive this form of treatment[6]. Long wait times for therapy and a lack of qualified CBT therapists are contributing factors. Group treatments are one potential way to increase accessibility to CBT, both in terms of offering services to clients, as well as providing an efficient method for training in CBT.

The group programs described were developed to address an increasingly long wait list for a CBT program. A psychoeducational group was considered because it could provide more rapid access to service and could enhance individual treatment by ensuring participants had the fundamental skills of CBT prior to entering more intensive individual treatment. Given that the primary presenting problems treated through the CBT program are depression and anxiety disorders, it was proposed that a psychoeducational "pre-individual therapy" group program be developed that would address the core components of treatment that are similar across these two diagnostic groups.

CBT Basics I.

A 6-session introductory CBT group program was developed to teach the fundamental concepts and techniques that apply to depression and anxiety disorders. *CBT Basics I* content is adapted from literature incorporating evidence-based CBT techniques, including Empirically Based Treatment Protocols[7,8,9,10] and various therapist and patient resources[11,12,13,14,15,16,17,18]. The overall structure and content of the group follows the typical stages of CBT skill integration, starting with behavioural techniques and moving towards cognitive techniques[19].

CBT Basics II.

CBT Basics II[20,21] was developed as a stand-alone treatment specifically for use in programs where group participants are unlikely to receive further individual CBT. The group length was extended from 6 to 10 weekly, 2 hour sessions, to allow for additional learning and practice of CBT skills for depression and anxiety. In addition, mindfulness meditation practice was added to the group, due to findings that mindfulness practice can reduce the risk of relapse in individuals recovered from depression[22] and reduce active depression and anxiety symptoms [23]. To date, *CBT Basics II* has been rolled out in 6 clinics across Alberta Health Services, including both mental health and medically-oriented programs and been completed by approximately 271 people. A total of 58 mental health practitioners (including Psychiatrists, Psychologists, Psychology Residents and practicum students, Nurses and Social workers) have been trained to co-facilitate the CBT groups.

Our findings.

Since its introduction in the Outpatient Mental Health Program in 2005, 160 clients have completed the *CBT Basics I* group. Results indicate significant reductions in depressive and anxiety symptoms and negative automatic thoughts, and significant increases in CBT knowledge. Results for *CBT Basics II* were similar[24] , with significant decreases in depressive symptoms and negative automatic thoughts at all sites, and significant reductions in anxiety symptoms at 4 of 6 sites. In addition, client use of mindfulness (MAAS) was found to significantly increase at most sites.

CBT Basics I and *II* are effective treatments for symptoms of depression and anxiety, as well as a promising training tool to increase the availability of trained CBT therapists. *CBT Basics I* appears to be a useful pre-therapy group that prepares individuals to engage in individual psychotherapy. *CBT Basics II*, with its longer time frame and increased opportunities to practice the skills taught, holds promise as a stand alone CBT intervention, in programs where individual CBT is not available. These preliminary results suggest that CBT Basics groups can be an effective intervention in general mental health programs, regardless of chronicity and severity of diagnosis, as well as for individuals with chronic medical illness.

Next steps.

Plans are underway to incorporate the program into other community clinics and inpatient programs within Alberta Health Services. A continued focus of the group is to provide CBT training for both multidisciplinary practitioners and trainees through a co-leadership model. Evaluation of the programs is expanding to address impact on readiness to change, duration of gains, and continued use of techniques learned.

Reference List available at http://www.cpa.ca/psynopsis

How Industrial and Organizational Psychology can Impact Innovation in Health Care

Thomas O'Neill, Ph.D., Elaine Gilfoyle MD, MMEd, FRCPC, Adam Cheng, MD, FRCPC, FAAP, Jeff Caird, Ph.D., University of Calgary

Imagine that a child patient experiences cardiopulmonary arrest. A resuscitation team is called to the scene to administer emergency life support. Each team member has a specialized role and communicates regular updates regarding the child's status to the other team members and to the team leader. The physician requests information about certain aspects of the patient's status and directs the team to administer medication and perform other treatments in a complex and highly dynamic environment. Such resuscitation events are life and death situations in which effective teamwork and leadership can save lives.

Given the critical importance of resuscitation team and leadership performance, we have launched a unique research program aimed at identifying the factors that are critical to effective resuscitations. Our collaboration of psychologists, human factors experts, and healthcare providers (e.g., physicians) leverages an interdisciplinary approach with the goal of identifying evidence-based best practices for medicine through simulation research. In this article we focus specifically on resuscitation teams, the specialized research of several disciplines, and how I-O psychology can contribute unique insight and innovation to the research.

Dr. Elaine Gilfoyle is spearheading the research on hospital pediatric resuscitation teams. Teams attend a day-long training program in which they respond to three different infant emergencies: asystole, shock, and dysrhythmia. Each simulation is video-recorded for later coding. The performances of the team and the team leader (i.e., lead physician) are of central interest. Accurate measurement of the team's performance is critical because the goal is to link team performance improvements to the team's adherence to Pediatric Advanced Life Support (PALS) guidelines developed by the American Heart Association. It is believed that close adherence to these guidelines offers children a better chance of survival from a cardiopulmonary arrest. Elaine's hypothesis is that improved teamwork performance will be positively correlated with increased adherence to PALS guidelines because following the guidelines involves structuring the many tasks and systematically working through numerous decision-making points. Strong team coordination, communication, and situational awareness is needed in order to successfully execute the guidelines during a resuscitation.

Dr. Adam Cheng is focusing on the styles and effectiveness levels of the simulation instructors. Instructor effectiveness scores will be linked to the new team performance and team leadership measures under development. This will yield creative new insights for "training the trainers," as instructors are often selected for their strong domain-specific expertise. Extensive domain-specific expertise, however, does not guarantee that an individual will be an excellent instructor, but a validated performance measure would be incredibly useful for orienting new instructors and developing important instruction objectives.

Dr. Jeff Caird and his graduate students are conducting human factors research on interruptions. Interruptions have been 'planted' in the scenarios; for example, in one scenario a mother disrupts the team by asking questions and refusing to leave the bedside. Other interruptions will occur naturally, such as with a sudden change to the patient's status or a request to briefly assist another team member. Reactions to interruptions, such as fixation (not attending to the primary task) and use of retrieval cues (e.g., referring back to the PALS card where the guidelines are printed) after the distracter is removed are hypothesized to be critical to the team's performance. Video recordings will be used to assess how team members and leaders managed interruptions and regained task focus afterward.

We point to four specific I-O psychology best practices that contribute to the potential for innovative health research outcomes. First, we are developing behavior-based measurement scales for quantifying team, leadership, and instructor performance using *behavioral observation scales*. This method involves identifying specific behaviors and reporting the frequency with which these behaviors occurred. Second, we aim to use I-O psychology to improve on existing teamwork and leadership measures that seem somewhat broad and ambiguous. For example, we will assess frequencies of specific, yet critical, behaviors that reflect dimensions of team performance (e.g., situational awareness, closed-loop communication, adaptability). Third, we will investigate the empirical factor structure of these new measures in order to identify the critical dimensions of team and leadership performance in resuscitation. Fourth, the frame-of-reference (FOR) procedure will be used to train the observers who will code team and leader behaviors. FOR training is a technique that I-O psychologists have shown to result in the greatest accuracy of observer ratings.

The above innovations delivered by I-O psychology are examples of valuable additions to the interdisciplinary research effort focusing on improving child patient outcomes of resuscitation events. The many disciplines involved (human factors, medicine, I-O psychology) have specialized expertise and unique measurement systems that complement each other synergistically. In fact, the challenges, complexities, and importance of optimizing the actions of personnel in infant resuscitation situations dictate multidisciplinary collaboration, as do many other important medical emergency situations (we are working with ambulance teams and on social factors affecting the use of defibrillators, for example). We are optimistic that collaborations of this kind can ultimately impact patients' quality of life and survival rates.

The Wait-List Clinic at the Canadian Mental Health Association – London Middlesex

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London Health Sciences Centre

While one in five Canadians will experience a mental illness in their lifetime, only one third of adults who currently need mental health services in Canada actually receive them[1]. Lengthy wait times for services, ranging up to 9 months, are common in community mental health[2,3]. No standards have been set for acceptable waiting times for mental health services in Canada even though delayed access to treatment is likely to exacerbate psychological concerns. Adults with severe mental illness who do not receive timely services are vulnerable to protracted emotional distress, occupational and social dysfunction, victimization, danger to self and/or others, physical health risks, and even incarceration[4,5]. Long wait times can result in clients becoming "dispirited", unable to cope with the challenge of engaging in treatments that require greater effort, and this can lead to decreased effectiveness of treatments[6]. Research also suggests clients are more likely to miss their initial mental health service appointment the longer they have to wait after referral[2,7]. Given timely access to mental health services is critical to successful treatment of adults with severe and persistent mental illness, there is a pressing need for initiatives that improve the quality of care for clients facing long wait times.

The **Wait-List Clinic (WLC)**, a partnership with Canadian Mental Health Association- London Middlesex (CMHA-LM), is an innovative project that aims to improve access to care for adults with severe mental illness in and around London, Ontario. The average wait time to receive community support and intensive case management services at CMHA-LM is 8 months and clients typically receive no other mental health services while waiting. The WLC at CMHA-LM was formed to reduce the isolation and suffering of these wait-listed individuals. With generous support from the Green Shield Canada Community Giving Program, the WLC opened its doors to CMHA-LM clients awaiting services in January 2012. The WLC operates twice a week in the evening, taking advantage of clinic space that would otherwise remain unused to serve clients. Trained student volunteers, working under the supervision of clinical psychologists, provide supportive client-centered counselling to CMHA-LM wait-list clients. Clients eligible for the WLC (e.g., those who are not actively self-harming) meet with their assigned counsellor until the service for which they are waiting is available, at which time they are discharged from WLC services. To date, a total of 20 clients have accepted services at the WLC.

The Wait-List Clinic (WLC) implementation strategy involves: a) maintaining face-to-face contact with CMHA-LM wait-list clients; b) providing supportive, client-centered counselling, where not contra-indicated (e.g., borderline personality disorder); c) monitoring CMHA-LM wait-list client functioning and service needs; and d) helping CMHA-LM wait-list clients

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High School Youth

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highlight student strengths (e.g., painting murals in the school, individual artwork highlighting individual strengths, student interest group development), and teachers are trained to use relevant research tools to assess student strengths over time. Experiential learning and cooperative placement opportunities assist in developing individual strengths in applied settings further building a sense of competence and positive contribution for youth.

The program also builds caring, trusting teacher-student relationships. These efforts are informed by research showing that caring teacher-student relationships are protective factors promoting positive student outcomes in spite of adversity[5,6]. On a practical level, SJB also provides thoughtful coordination of community services for their students, in hopes of establishing the school as a central hub where youth may easily access the services they require. For example, students have access to mental health intervention at school and the school social worker engages in case management onsite including the coordination of community partners such as Family and Children's Services, Community Mental Health and Justice Services. This integrated delivery of services allows families and community partners to work and communicate more directly and effectively with each other to provide youth with a more seamless circle of service and care.

Researchers from Dr. Margaret Lumley's laboratory at the University of Guelph have collaborated with the school to conduct research assessing the effectiveness of the SJB program from the student's perspective. Teacher-student relationships seem to be flourishing in this environment with self-report data suggesting that 97% of students agree that their teachers care about them and are there for them when they need them. In addition, in this high-risk sample, emotionally secure relationships with teachers were associated with positive self-concept, social-emotional assets, and student engagement. Taken together these data suggest that the school's strong effort to identify and foster student strength, even amongst youth with significant risk and challenge, is quite promising.

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Wait-List Clinic

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maintain or achieve readiness for eventual community support/intensive case management services. By providing counselling and support on an individual basis, the WLC helps clients manage the stress and loneliness that they might otherwise experience without such support while waiting for the services they need. Clients can experience symptom relief while waiting, which can positively impact their overall treatment outcome (i.e., better prognosis). We hope that maintaining contact with CMHA-LM wait-list clients will reduce the likelihood of clients being 'lost' from wait-lists and that clients will be more likely to accept services and attend future treatment appointments when they become available. Moreover, providing regular feedback about client needs and progress (e.g., level of functioning, readiness for service) to relevant CMHA-LM staff may afford an improved system of resource allocation and wait-list reduction for CMHA-LM.

Another goal of the WLC program is to teach students a variety of basic counselling skills in a multi-disciplinary mental health community setting. The clinic is arranged such that supervisors and students not providing direct service observe sessions via live video feeds from counselling rooms. Providing such vicarious learning experiences for students promotes case discussion and fosters a high-degree of quality assurance at the WLC. Feedback sessions with students revealed that their exposure to the WLC client population was very effective at dispelling the stigma surrounding adult mental illness. Ongoing development of the novel collaborative training model at the WLC is directed at improving students' readiness to work in community mental health settings and expanding students' skill sets for working collaboratively with this client population.

A comprehensive program evaluation is being conducted to determine the effectiveness of the WLC service delivery model and program processes. Desired program outcomes are not likely to be achieved unless the program is implemented as intended[8]. Thus, evaluating the implementation of the WLC is a crucial first step in determining how effective the WLC service delivery and training models are in meeting short- and long-term goals at both the client and agency level. Preliminary findings of the 9-month pilot trial demonstrate the WLC benefits wait-listed clients and student therapists alike. The WLC initiative can assist community mental health agencies, like CMHA-LM, to make more efficient and ethical wait-list determinations by using periodic assessment of wait-listed clients' strengths and needs.

It is imperative that researchers and policy makers continue to support management of lengthy waiting lists for adults with severe mental illness. Examining the effects of brief client-centered counselling on wait-listed clients' mental health service utilization can provide valuable insights to understanding how to deal with common efficiency problems, such as wait-list attrition and low attendance rates, at community mental health agencies. For this reason, the Wait-List Clinic is looking to expand its client population and to extend its pilot trial into 2013.

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Shared Mental Health Care

Alberta Health Services

Gene Flessati, PhD., R.Psych., Alberta Health Services

Shared Mental Health Care (SMHC) is an innovative multi-disciplinary mental health consultation service in Calgary, Alberta that partners family physicians with mental health specialists including psychologists, social workers and psychiatrists, with the goal of enhancing the quality of mental health services delivered to individuals within the primary care setting. The program was created in 1998 in response to concerns that the current publicly funded mental health delivery model was not adequately meeting the mental health needs of the population (e.g., excessively long wait lists, difficulty accessing services, poor communication between physician and mental health program, patient refusal to attend specialized mental health services) and because of physicians' concerns regarding their ability to recognize and manage mental health concerns in their practice.

Ongoing physician-consultant communication and feedback, and attention to the development and maintenance of strong physician-consultant relationships are key components of both programs.

Two complementary programs (***Shared Care Service*** and ***Behavioural Health Consultation Service***) operate within SMHC. In both programs, mental health consultants work directly with physicians and their patients in the primary care setting. Ongoing physician-consultant communication and feedback, and attention to the development and maintenance of strong physician-consultant relationships are key components of both programs. Each service will be briefly described.

Shared Care Service

The Shared Care Service was the first program developed in SMHC. Family physicians who participate in the Shared Care Service (SCS) contract to work directly with a consultant for 1 to 8 hours each month. This program has two main objectives: increasing family physicians' ability to identify and manage mental health concerns; and, direct delivery of mental health services within the primary care setting. Upon enrolment in the program, the physician is partnered with a consultant, and their initial tasks are to discuss learning objectives of the physician as well as the mental health needs of patients in the physician's practice. Based on learning objectives and identified patient needs, the physician then selects patients to participate in the SCS. Consultation services include patient assessment and intervention/therapy, as well as physician education activities (e.g., discussion of psychological interventions) that are jointly decided upon by physician and consultant.

The most unique aspect of the program is that the physician and consultant are both present for each shared care consultation session, and are partners in the provision of mental health care to the patient. Consultation appointments are typically one hour, with post consultation discussion and feedback following each session. Intervention is short term, and most patients are seen for less than 7 sessions. Physicians' participation in the SCS is compensated through an alternative payment plan.

Behavioural Health Consultant Service

Although the SCS was very positively evaluated by both physicians and patients who participated in the program, only a small percentage (10-15%) of physicians in Calgary had access to the program, with many physicians not willing to participate in the SCS because of the physician time commitment required by the SCS model. The Behavioural Health Consultation Service (BHCS) was developed in 2006 in response to physician requests to expand the SCS model to allow greater access to mental health care within the primary care setting without the requirement that the physician participate in consultation sessions. In this program, the behavioural health consultant is fully integrated into the primary care practice. Behavioural health consultations occur in the physician's clinic, with the goals of minimizing barriers to accessing behavioural health consultations, and optimizing physician-consultant communication. Consultations target traditional mental health concerns as well as other behavioural health concerns that place the individual at increased risk of developing physical or mental health difficulties in the future. Sessions are typically 30 minutes and most patients are seen for a maximum of 4 sessions.

There have been several comprehensive evaluations of these two programs, and the vast majority of the findings have been positive. Some of the more important findings include:

- Patients referred to SMHC received mental health assistance in a timely manner (e.g., 81% of patients in the BHCS were seen by a behavioural health consultant within 19 days of physician request).
- The vast majority of patients (~ 90%) seen in either SMHC service remained under the family physician's care, with only a small percentage of patients who participated in SMHC being referred for mental health services outside of the primary care setting. This finding suggests that SMHC was meeting most physicians' and patients' needs, and also reducing the burden on the mental health system.
- The vast majority of patients seen in either service experienced improvement in functioning following their tenure in the service, with very few patients experiencing deterioration in functioning (as assessed by a number of measures that were independently completed by patient and physician). (Note: interpretation of these data is limited by the lack of

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Providing Psychological Services and Training in Primary Care:

Ryerson University and St. Michael's Hospital

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Current statistics indicate that 20% of Canadians experience a mental health problem in any given year, translating to 43% of the country's population experiencing a mental health condition over the course of their life.[1] The efficacy of psychological therapies for a range of psychopathology, including depression, general anxiety, social phobia, agoraphobia, substance abuse, eating disorders, posttraumatic stress disorder, and panic, are well-documented.[2-5] Yet, many Canadians do not have access to therapies for these conditions because their costs are not covered by public health insurance plans. The new Canadian Mental Health Strategy, developed by the Mental Health Commission of Canada, advocates for increased access to mental health care, including evidence-based psychotherapy, in primary care settings.[6] In Ontario, the revolution in primary care delivery has seen the creation of over 170 family health teams (FHTs) in the last decade. Each FHT is each uniquely designed to deliver primary care based on the local health and community needs of their catchment area. The Ryerson University Clinical Psychology Program and St. Michael's Hospital Family Health Team in downtown Toronto have partnered to provide Canadians with access to psychological therapies at no direct cost within a family healthcare setting. With the opening of the Ryerson University Clinical Psychology Training Clinic (CPTC) in June 2011, adult patients have access to psychological services provided by 12-14 Clinical Psychology graduate students from Ryerson University, under the supervision of the Clinic Director and Ryerson faculty.

The Health Centre at 80 Bond is committed to interdisciplinary, team-based service delivery and the training of family physicians, social workers, dietician, nurses, chiropractors, pharmacist, dentists, and psychologists. This pioneering training experience allows Clinical Psychology students to gain first-hand, practical experience working with community members from a range of cultural and socio-economic backgrounds, including urban professionals, recent immigrants, and homeless persons, in a hospital-based, primary care setting. Designed to deliver high quality services and training, the state-of-art facility uses cutting edge technology to provide patients with psychological assessments and evidence-based interventions for a wide range of psychological disorders and varying levels of case complexity and symptom severity.

The CPTC was recently awarded a $40,000 Bell Canada Let's Talk Community Fund grant. This funding will be used to improve patient access to psychological services, increase patients' capacity in relation to mental health and chronic disease management, and strengthen the CPTC training program. In addition, the Health Care Innovation Working Group (2012) identified the St. Michael's Hospital FHT model, including the CPTC, as an exemplary and innovative model, only one of four primary care clinics in Canada to receive the distinction.[7] The report recommends that this model be monitored and evaluated to facilitate replication by other primary care clinics across Canada. In the coming years, the CPTC will look to expand their psychological services to children and teenagers, explore ways to further support other FHT professionals, particularly in relation to chronic disease management, and conduct interdisciplinary evaluative research on the model and inter-professional collaboration.

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SMHC

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experimental control)

- Physicians reported increased comfort and skill in identifying and managing mental health concerns, as well as increased knowledge about mental health services in the community.
- Patients and physicians in both services rated the quality of the service very favourably.

On a personal note, I have worked in the SCS for slightly over a year, after working in publically funded outpatient mental health settings for 20 years. Although I initially had reservations about practicing in such a novel manner/environment, I have found this to be a rewarding career change, and am frequently awed by the rapidity of patient change that occurs in this context. Based on my experience in this program, I believe that many physicians, and their patients, would benefit from participation these types of collaborative care ventures.

The psychological side of health: Innovations in service delivery for person with chronic conditions

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The relationship between psychological difficulties and health problems is well established (Felitti, 1998). Despite this knowledge, the medical community tends to focus almost exclusively on medication and psychoeducation to treat mental health issues in the health population. Unfortunately, in many instances where patients appear to be unmotivated to make behavioural changes (e.g., smoking cessation, dietary management for diabetes, exercise) or are noncompliant with medical recommendations, the core problem is essentially psychological. When treatment is focused almost exclusively on biological factors, health care practitioners fail to address the underlying psychological issues impacting physical health.

Short term dynamic therapy has been shown to be effective for patients with chronic health conditions. A recent meta-analysis, involving 23 randomized controlled trials, yielded an overall effect size of 0.97 for general symptom improvement and the effect size increased to 1.51 when the patients were assessed at long term follow up (Abass et al., 2006).

Relying on this literature, the authors developed an innovative screening and treatment program designed to address underlying psychological problems in a health population. To accomplish this, a collaborative partnership between the Department of Clinical Health Psychology and Chronic Disease Management was established. For this program, all patients in the cardiac rehabilitation and the diabetes education programs are screened as part of the recruitment process. Patients scoring above the cut off on any one of five items on the STOP-D (ratings of sadness, anxiety, stress, anger and lack of social support; Young et al., 2007) or those who health personnel suspect are at high risk (using additional screening questions), are offered the option of a referral to a group psychodynamic psychotherapy program and are provided with the Inventory of Interpersonal Problems (IIP-64; Horowitz, 1998). Once this instrument is completed, patients are invited for a clinical interview with one of the clinical health psychologists, at which time they complete the Symptom Checklist 90 (SCL-90-R; Derogatis, 2004). During the interview, patients are further assessed to determine the suitability of a process group to meet their needs. The theory underlying the group is discussed, emphasizing a focus on the processing of unresolved trauma, exploration of the avoidance of intense affect, and the development of healthier and more adaptive emotional and relational functioning. For each patient, a clear focus for treatment is formulated.

With a Short Term Psychodynamic approach, discussion of content related to the illness is discouraged. Patients are encouraged to explore the origins of current dynamics. For example, group members struggling to manage diabetes frequently developed problematic eating habits early in life. As children, these individuals tended to use food as a mechanism of self-soothing when distressed, and eating may have been their only means of coping with distressing circumstances. However, as adults, these individuals have options regarding their coping mechanisms, yet tend to fall back on familiar coping strategies. Through the group process, patients are encouraged to examine the unhealthy ways that they have coped with overwhelming emotional distress in the past (e.g., food, smoking, alcohol, drugs, sexual promiscuity, suicide attempts) and learn to identify and address these powerful emotions in a healthy and adaptive manner.

The structure of the group allows for rolling enrolment, with patients entering on an ongoing basis. We have found this process particularly beneficial as current participants are already engaged in intense emotional processing. As new members witness ongoing treatment, they become familiar with how the group works and become desensitized to the impact of intense emotion. On numerous occasions, new members added to the existing group minimally participated in early sessions but later report important insights and take crucial steps toward dealing with a lifelong trauma (e.g., engaging family members in discussions over historical and shared trauma). Sessions are not limited and participants are encouraged to continue with the group until they have improved their self-care.

Data collection begins prior to group entry and on an ongoing basis every six sessions, with all three measures being repeated. At this time, very little data is available. However, preliminary data analysis indicates that overall total scores, on both the IIP-64 and the SCL-90-R, tend to increase from the initial screening to the time of the first group and decrease with the commencement of treatment. For the STOP-D, patients are meeting the cut off for more items at the time of the initial screening than at subsequent measurement points. The preliminary results suggest that the clinical interview and the process of developing the central dynamic sequence may be contributing to an increase in symptomatology. Once patients join the psychotherapy group and begin to understand how avoidance of intense affect, adoption of maladaptive coping strategies, and poor relational functioning contribute to their distress, a decrease in symptomology is experienced.

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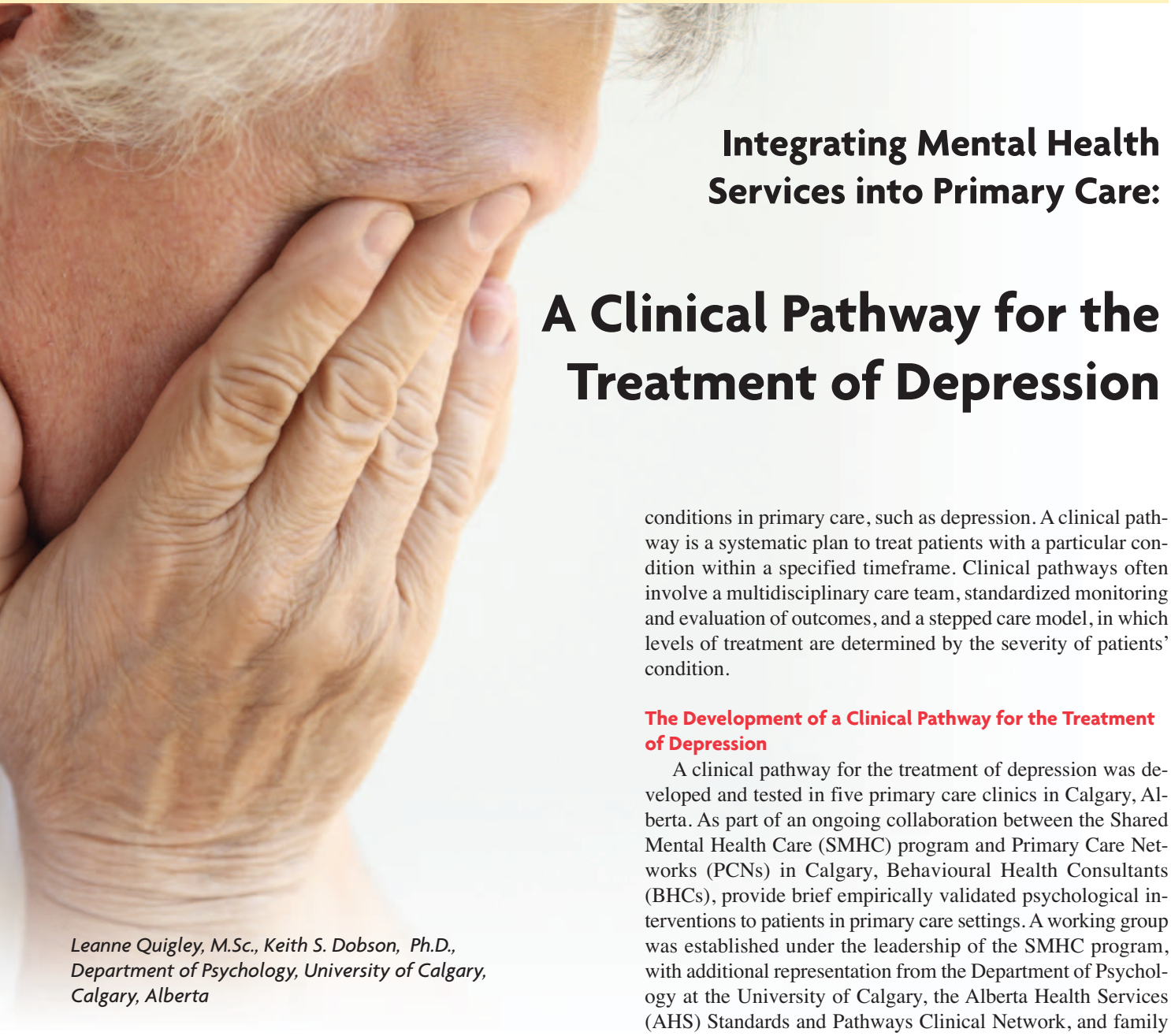

Integrating Mental Health Services into Primary Care:

A Clinical Pathway for the Treatment of Depression

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Depression is a major public health concern, since about 5% of Canadians experience an episode of clinical depression each year, and the economic cost associated with depression is estimated at over 14 billion annually in Canada. Unfortunately, only about half of depressed individuals receive any treatment, and typically such treatment falls short of adequacy standards. There is a need for innovative approaches to the treatment of depression that increase access to services and improve quality of care. Clinical pathways have been increasingly recognized as one of the best ways to address high frequency and high cost conditions in primary care, such as depression. A clinical pathway is a systematic plan to treat patients with a particular condition within a specified timeframe. Clinical pathways often involve a multidisciplinary care team, standardized monitoring and evaluation of outcomes, and a stepped care model, in which levels of treatment are determined by the severity of patients' condition.

The Development of a Clinical Pathway for the Treatment of Depression

A clinical pathway for the treatment of depression was developed and tested in five primary care clinics in Calgary, Alberta. As part of an ongoing collaboration between the Shared Mental Health Care (SMHC) program and Primary Care Networks (PCNs) in Calgary, Behavioural Health Consultants (BHCs), provide brief empirically validated psychological interventions to patients in primary care settings. A working group was established under the leadership of the SMHC program, with additional representation from the Department of Psychology at the University of Calgary, the Alberta Health Services (AHS) Standards and Pathways Clinical Network, and family physicians from the five PCNs involved in the project. The group established and developed the pathway protocol based on empirically supported best practices.

The Clinical Pathway

The pathway was developed to provide the appropriate level of care for patients at different levels of depression. As such, ongoing patient evaluation was a key aspect of the protocol. The Patient Health Questionnaire-9 (PHQ-9) was the primary measurement tool for the pathway. It is a valid and reliable self-report questionnaire that is designed to assess depression based on DSM-IV criteria. Physicians and BHCs administered the PHQ-9 to assess for depression if: a) the patient complained of depressive symptoms; or b) the physician or BHC had reason to suspect the presence of depression.

Patients were assigned to different levels of care based on their PHQ-9 scores. Patients who scored below 10 on the PHQ-9 were not eligible for the pathway and did not receive any intervention or follow-up. Patients who scored between 10 and 14 on the PHQ-9 were assigned to the Watchful Waiting group. These patients did not receive any intervention, but were given some information and scheduled for a follow-up appointment approximately 4 weeks later to monitor PHQ-9 scores. Patients who scored between 15 and 19 on the PHQ-9 were placed in the Moderate Intervention group. These patients were offered one specific intervention strategy, either antidepressant medication or BHC sessions focused on cognitive-behavioral therapy skills. Furthermore, physicians scheduled patients in the Moderate Intervention group for at least three follow-up sessions over the next 3 months. Patients who scored 20 or higher on the PHQ-9 were assigned to the High Intervention group, and offered two specific intervention strategies (i.e., antidepressant medication and BHC sessions). They were also scheduled for at least three follow-up sessions over the next 3 months. The PHQ-9 was re-administered at all follow-up sessions, and further pathway involvement was determined on the basis of PHQ-9 scores. All pathway patients were also offered self-management modules that were designed to provide information about depression, and present evidence-based interventions and coping skills for patients.

Outcomes

Successful completion of the clinical pathway was defined as a score of less than 10 on the PHQ-9. Patients who successfully completed the pathway were removed from the pathway, and scheduled for a follow-up session 3 months later to assess for recurrence of symptoms. A total of 158 patients were placed on the clinical pathway during the pilot test; 39% were in the watchful waiting category, 34% were in the moderate intervention group, and 27% were in the high intervention group.

The overall successful completion rate for all patients who had entered the pathway at least 6 months prior to evaluation was 56% and the mean change in PHQ-9 scores was -8.29. Patients in the Low Intervention group had the best outcomes, and highest rates of program completion. Thus, patients enrolled in the pathway showed positive results that are consistent with the level of positive treatment responses found in trials of empirically validated treatments for depression. The positive treatment results were achieved with minimal investments of time by the physician (1.75 visits per patient on average) and the BHC (1.45 visits per patient on average).

Conclusions & Next Steps

The results of the pilot test of the clinical pathway suggest that patients with depression can be successfully treated in primary care settings with less investment in treatment resources than typical psychological interventions. Both physicians and patients reported that use of the PHQ-9 improved the treatment of depression in the clinics. Having a consistent measurement tool helped physicians know which patients to include on the pathway, helped patients understand and track their own progress, and assisted in clinical decision making about the level of intervention that a patient should be offered. The working group is now involved in the second phase of the project, which includes the development of an electronic registry for monitoring and collecting data, and implementing the pathway into a larger number of clinics across the greater Calgary area and in Alberta more generally.

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Bounce Back: Reclaim Your Health

A telephone-supported, cognitive behaviour therapy-based self-help program for primary care patients with mild-moderate depression

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Lifetime prevalence rates of Major Depressive Disorder in Canada are between 10-12%, with approximately 1.5 million Canadians reporting depression in any given year. As depressed patients are often in frequent contact with their primary care physicians for other health problems, effective depression treatment and management currently relies heavily on the primary care sector. The Canadian Network for Mood and Anxiety Treatments Clinical Guidelines (CANMAT) recommend antidepressant medication and cognitive behaviour therapy (CBT) as first-line treatments for depression. Both can be effective in treating depression; however, some patients may experience side effects when taking antidepressant medications or prefer psychotherapy. Moreover, the National Institute of Clinical Excellence (NICE) Guidelines from the United Kingdom specifically recommend CBT before pharmacotherapy for individuals suffering from mild to moderate depression. Despite the wide spread acceptance and validation of CBT, these services are not always readily available or accessible, especially to those individuals living in rural areas.

One promising way to bridge the CBT service delivery gap has been the development of low intensity/high capacity CBT interventions such as bibliotherapy. Bibliotherapy is a self-education intervention in which participants are given reading materials in the form of manuals, and/or other take home materials such as audio/video recordings. These types of resources can be effective in teaching individuals with mild to moderate symptoms the key principles of CBT in order to help them self-manage their psychological symptoms. This type of intervention can involve no contact with a therapist or, in the case of supported bibliotherapy, can involve minimal contact with a supporter or coach, for example, in-person or via the telephone. Guided self-help has been shown to be more effective than self-help alone, irrespective of whether support is provided by mental health specialists or non-specialists. Furthermore, for patients coping with chronic physical illness(es) and multiple medical appointments, the availability of telephone support can offer many advantages including privacy, accessibility, and convenience.

Bounce Back: Reclaim Your Health is a low intensity/high capacity CBT intervention that was designed based on the above described new developments. This program, led by the Canadian Mental Health Association's British Columbia (BC) Division and funded by the BC Ministry of Health, was implemented in 2008. *Bounce Back* offers mental health support to individuals experiencing mild-moderate depression with or without anxiety. The *Bounce Back* materials derive from Dr. Chris Williams' '*Living Life to the Full*' program which includes a psycho-educational DVD and a self-help manual, *Overcoming Depression and Low Mood: A five areas approach*. These materials are offered to patients along with three to five

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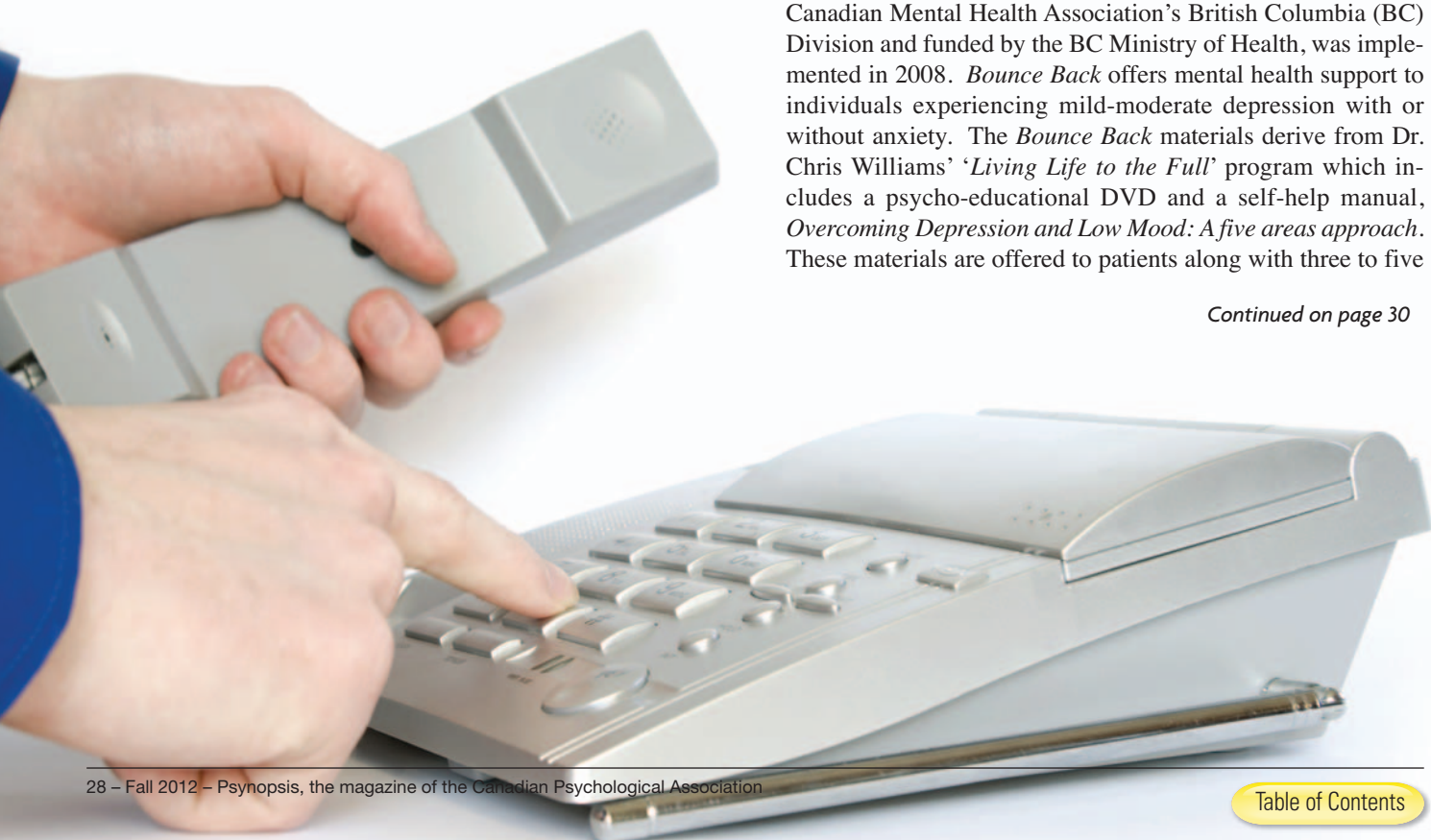

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Treating Insomnia in Primary Care:
A Key Role for Psychologists

Judith R. Davidson, Ph.D., C. Psych., Kingston Family Health Team and Departments of Psychology and Oncology, Queen's University, Kingston, Ontario

It is estimated that 52-64% of patients seen in primary care (i.e., at the office of a family physician) have sleep complaints and 10-40% have severe insomnia that interferes with daytime functioning[1-3]. Insomnia tends *not* to resolve without treatment, and many people suffer for years without effective help. For example, the average duration of insomnia for patients arriving at a Canadian insomnia clinic was 11 years[4]. Providing relief from the burden of insomnia itself is important enough, but there are other reasons to treat it early. Over the past 15 years, it has become clear that insomnia is a risk factor, an early marker, for major depression[5]. In addition, people with insomnia use disproportionately more mental and health care resources[6]; and this is seen directly in primary care[7].

Hypnotic medication, especially benzodiazepine receptor agonists (BzRAs), can be useful for acute insomnia, but because of side-effects and tolerance, this approach is not appropriate for chronic insomnia (insomnia that lasts one month or longer). Primary care physicians are aware of the problems with long-term use of BzRAs and encourage initiatives to reduce their use[8]. However, the most appropriate treatment for chronic insomnia, cognitive behaviour therapy for insomnia (CBT-I), is rarely available in Canadian communities at this time.

CBT-I has plenty of evidence of efficacy and is the recommended first line treatment for chronic insomnia[9-11]. CBT-I works, not only for patients with "just" insomnia, but for patients with comorbid conditions such as chronic pain, cancer, heart disease, and depression[12]. CBT-I can also lead to improvements in the comorbid condition itself (e.g., in the case of depression[13] and pain[14]). Improvements in sleep are sustained for at least 2 years after treatment[15].

Psychologists who have training in behavioural sleep medicine are needed particularly in primary care when insomnia is first reported. The clinical effectiveness of CBT-I in primary care has been demonstrated by psychologist Dr. Colin Espie and colleagues in Glasgow, Scotland[16]. At the Kingston Family Health Team, we have developed a Sleep Therapy program for patients with chronic insomnia that works well.

The Sleep Therapy Program

Patients with chronic insomnia are seen by the Team psychologist for a sleep assessment interview. Before this, they complete sleep forms, sleep diaries, the Insomnia Severity Index[17] and self-report measures of mood. The assessment interview screens for other sleep disorders, determines the type of insomnia, and identifies the factors that contribute to, and that perpetuate, the sleep problem.

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Insomnia

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Patients with insomnia are then offered the Sleep Therapy group program. Sleep Therapy uses CBT-I. There are six weekly sessions, each lasting two hours. Groups have 3-10 patients, and are co-led by the psychologist and a nurse practitioner or a program assistant. In Session 1, patients learn about insomnia, sleep stages and cycles, sleep and age, effects of sleep loss, and the homeostatic and circadian processes that regulate sleep and wakefulness. They log their sleep through the week as they maintain a constant rise. In Session 2, patients learn diaphragmatic breathing, are introduced to cognitive techniques to examine their troubling thoughts about insomnia, and they begin Stimulus Control Therapy[18] with Sleep Restriction[19]. They continue with stimulus control therapy with sleep restriction though the program, logging their sleep with sleep diaries, and adjusting their bedtime each week according to standard protocol[20]. Patients also learn relaxation techniques (body scan and visualization exercises). Session 6 is a review that focuses on maintenance of good sleep.

Outcomes

Sleep diaries and the Insomnia Severity Index, both standard measures of insomnia, are used to measure initial and post-program sleep. Data from our first 33 patients show that time to fall asleep, time awake during the night, and early morning awakening duration were significantly shorter, at the end of the program than before the program (paired t-tests, $p<.01$). Except for total sleep time, all other sleep measures were significantly improved after the program, including ratings of sleep quality and insomnia severity. In addition, hypnotic medication use was significantly lower after the program, and self-reported anxiety and depressive symptoms were significantly improved.

Conclusion

The Sleep Therapy program described here shows how patients can receive effective treatment for insomnia shortly after they report their problem to the family physician. CBT-I is the recommended treatment for chronic insomnia but it is rarely available in Canadian communities. Psychologists with behavioural sleep medicine training are the professionals best suited to provide this treatment. We hope more psychologists across Canada can learn to provide CBT-I and that their services can be incorporated into primary care teams - thereby providing access to a needed and effective treatment.

Reference List available at http://www.cpa.ca/psynopsis

Bounce Back

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telephone support sessions from non-specialists who are trained and monitored by a registered psychologist. The telephone sessions, scheduled approximately every 2 weeks, are 20-40 minutes in length for a total contact time of approximately 2 hours.

The *Bounce Back* service has three key features. The first is immediate access for the patients to a brief intervention for depression (the *Living Life to the Full* DVD) at the point of contact with their family doctor. This DVD is a 45-minute video drawing on examples from real individuals suffering from depression. It covers a number of common life skills that most people can learn in order to get more enjoyment out of life (e.g. problem solving, building confidence and dealing with unhelpful behaviours, sleeping better, healthy living, assertiveness, and balanced thinking). The second feature is the provision of tele-health services that bring mental health support to patients in their own homes. The supporters, working through CMHA branches that cover referrals from the entire province, help patients choose and complete relevant sections of the *Overcoming Depression and Low Mood: A five areas approach* materials. Thus, the telephone delivery model provides services to patients of primary care practices in local and, importantly, in outlying communities. The third key feature is the provision of support or coaching. Coaching is not the same as counseling or therapy. Coaching enables patients to engage with and get the most out of the materials. Advantages include privacy, accessibility, and convenience, especially for those patients living in rural areas and cannot access treatment due to geographic barriers; those who do not seek treatment due to stigma; or those who are coping with chronic physical illness and multiple medical appointments. These features combine to make *Bounce Back* an intervention that can reach a large number of individuals through a brief, easy to implement service.

Independent evaluation of *Bounce Back* has shown full implementation, with sound clinical quality assurance, monitoring and risk management processes. In addition, there is growing support from primary care for this program and is perceived by stakeholders as a credible and valued intervention. Quantitative data obtained from over 3000 *Bounce Back* patients with mild to moderate depression completing three to five telephone support sessions demonstrate significant reductions in mood and anxiety symptoms as well as improved physical health and quality of life. Finally, a controlled evaluation of the *Bounce Back* program is currently being conducted in Alberta. This study will help determine the cost-effectiveness of the *Bounce Back* program.

Bounce Back is available for persons in every community in BC through their regular family physician; at present the program is not open to self-referrals or referrals from other agencies. Details of how to make a referral can be found at http://www.cmha.bc.ca/services/bounceback.

The First Mental Health Strategy for Canada

Fern Stockdale Winder, Ph.D.
Psychologist, Saskatoon City Hospital
Vice-Chair, Board of Directors, MHCC
With input from Howard Chodos, Ph.D.
Special Advisor, Mental Health Strategy for Canada, MHCC

On May 8, the day of the national launch of the first mental health strategy for Canada, I was on the bus riding from Saskatoon to Regina. Via webcast, I was able to virtually join my Mental Health Commission colleagues in Ottawa for one of the most momentous days in the history of mental health in Canada. As any of you who have travelled the highway from Regina to Saskatoon know, the scenery encourages reflection. As I watched the webcast, I was greatly moved by the openness of Valerie Pringle, the continued energy of the Honourable Michael Kirby, and the quietly dynamic and committed presence of Howard Chodos, one of the lead authors of the *Strategy*.

The creation of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* was an amazing process. It reflects the experience, knowledge and insight of Canadians in every province and territory, from people who are living with mental health problems and illnesses and their family members, to the care providers who work with them as well as experts in all areas of mental health. Psychologists from across the country have been involved at every stage of the process.

The *Strategy* draws on our deepening understanding of the psychological, biological, and environmental factors that contribute to mental health problems and illnesses. Grouped under six Strategic Directions, its 109 recommendations balance the importance of promoting mental health and preventing mental illness wherever possible with the need to ensure that everyone who confronts a mental health problem, no matter how complex or severe, is able to count on quality services, treatment and support where and when they need them.

The *Strategy* reflects an understanding that mental health is much more than just a health issue and addresses the range of factors – from being socially involved to having access to decent housing – that influence mental health. It recognizes that the opportunity to achieve the best possible mental health does not come equally, and pays attention to the specific obstacles faced by the many diverse communities across the country in accessing appropriate services. It acknowledges the distinct circumstances, rights and cultures of First Nations, Inuit, and Métis and places a great emphasis on working with them to address their mental health needs.

The *Strategy* presents recommendations that touch on just about every dimension of our work as psychologists. The third Strategic Direction, which is about ensuring timely access to the right combination of services, treatments and supports, contains one that may be of particular interest to psychologists who provide psychotherapy. The *Strategy* recommends better access to psychotherapies and clinical counseling, and places a special emphasis on the importance of ensuring that children and youth do not face financial barriers in obtaining access to them (recommendations 3.2.4 and 3.2.5).

As with all its recommendations, the *Strategy* does not present a detailed plan on how to achieve this objective. Implementing many, if not most, of its recommendations will require the continued active engagement of people across the mental health system, including people with lived experience, family members, mental health professionals, administrators, and researchers.

The *Strategy* is not just for Governments. Rather, it issues a challenge to each of us as citizens and as psychologists: work to raise public awareness and to galvanize action on what matters in each region, province and territory, and to the country as a whole.

As I emerged from the bus on that day on May 8th, I was encouraged and heartened to be part of a larger movement working toward change. Indeed, the response to *Changing Directions, Changing Lives* has been overwhelmingly positive amongst stakeholders across the country. There was widespread media coverage of the national launch, and by the end of the year a regional launch will have taken place in every province and territory. I moved toward my speaking engagement with staff from the Saskatchewan Ministry of Health with renewed energy. No matter where your "bus" of advocacy takes you, I invite you to work with the Mental Health Commission, to use the Mental Health Strategy, and to become part of the growing group of Canadians working for change.

Querying the 10-Hour Per Week Rule in Graduate Clinical Psychology

Sabrina Hassan, M.A., Ph.D. Candidate

Graduate students will recognize the rule stipulating they may not work more than 10 hours weekly (hereafter, the Rule) while registered full-time. This guideline is intended to protect time for studying, research, and clinical training activities; as such, it is readily accepted by most students and faculty. But I think there should be more flexibility in considering paid experience alongside clinical graduate study.

Many individuals seek experience in professional mental healthcare before undertaking graduate training, to develop familiarity with the field and make informed career decisions. Prior experience also provides time for emotional and professional development; for this reason, some clinical programs in the U.S.A. only accept students with prior professional experience. In Canada, similar requirements are seen in related programs, e.g., OISE's Counselling Psychology for Community and Educational Settings program. Maintaining employment while pursuing graduate studies follows naturally from this line of thinking and, in fact, many individuals from allied professions work while simultaneously pursuing professional degrees.

A benefit of working in clinical settings while pursuing graduate study in clinical psychology is that experience and education often complement each other. For example, rather than learning about psychopathology in a strictly intellectual way, students with professional experience come prepared with real-life examples of the same phenomena. Professional experience also enables students to challenge personal biases and encourages clinical sensitivity and compassion. Furthermore, certain issues, such as the influence of the pharmaceutical industry on research and treatment, are more readily grasped by those who have had opportunity to observe how these play out in applied settings. This facilitates more sophisticated analyses of clinical concepts and issues, which befits those undertaking doctoral training. Often, students who are working professionals are also afforded additional opportunities for research involvement, including publications, conferences, and supervision of research activities, and for supervised clinical practice. With the reality of competitive practicum and internship applications facing every student, it makes sense that additional relevant experience would be only beneficial. This is underscored by the fact that analogous opportunities within the university vary in number and availability, resulting in some students not having (as much) access to these experiences.

More generally, working in a clinical setting provides individuals with a sense of professional identity. Experience and knowledge (both positive and negative aspects) of the profession instill confidence and purpose that may take less experienced individuals time to develop. Awareness of role-expectations and staff membership can also facilitate belonging and self-worth. The financial benefits conferred by working can reduce the related stress

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many students experience and allow attendance of costly but valuable clinical training workshops and academic conferences, often as an employment benefit. This is particularly meaningful given externally-funded scholarships are not available for every student and university-based financial support is often limited. But perhaps the biggest advantage of working while pursuing graduate study is the opportunity to network with other professionals and to develop a public professional identity. This increases one's prospects for practica, internships, and securing more permanent and desirable employment upon graduation.

Why, then, maintain the Rule? CPA and APA accreditation, which set clinical psychology training standards, have impelled many graduate programs to adopt a professional school model of administration wherein time to degree completion is significant. Also, some faculty/administrators are mindful of the potential for attrition and for irresponsible practice in employment settings, beyond students' competence and/or without appropriate supervision. Finally, a culture of "infantilization" characterizes many graduate programs, whereby students' trainee status devalues accumulated experience and knowledge.

The infantilization that occurs is unjustified and negatively affects students' morale and self-esteem. Indeed, working may prolong some students' training; but students balancing multiple priorities are often more focused in their pursuits, enabling them to graduate within prescribed time limits. Concerning some students, fears of irresponsible practice may also be founded; but in many clinical settings there is commitment to ensuring employees are provided supervision according to respective professional college requirements. Most importantly, the position of the Ontario Council on Graduate Studies (OCGS) is that while students' time should be protected, "it is not possible or desirable for the university to monitor and enforce the employment activities of its graduate students outside the university" (http://ocgs.cou.on.ca/_bin/home/employment.cfm).

In line with the OCGS, I feel the Rule infringes on individual rights and freedoms. If students fulfill program requirements, especially while maintaining timely progress, how can monitoring students' employment activities be justified? Furthermore, differing interpretations of the Rule – e.g., is It confined to work within the university? – contribute to inequitable inconsistencies among students. Individual students can circumvent the Rule by not disclosing their employment, essentially maintaining their paid positions without sacrificing their academic standing. Some, however, must choose between education and employment for personal financial reasons. Others can maintain paid positions but are relegated to part-time status (irrespective of actual academic progress), rendering them ineligible for funding usually based on merit and vital to securing future academic positions.

Equality sometimes necessitates differential treatments to balance inequalities among persons/groups. Given some students feel protected by the Rule, others are affected by limited opportunities, and inevitable differences in personal circumstances, it does not make sense to maintain a "one-size fits all" approach to student employment. The decision to work, including number of weekly hours, ought to be made, if not individually, then in consultation with one's supervisor. This is a call for clarity in the parameters of the Rule and for flexibility within graduate programs to offset inequalities in opportunities and circumstances among students.

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Keynote Speakers

Honorary President's Address

Honorary President's Address
The Honourable Mr. Justice Edward F. Ormston

The Honourable Mr. Justice Edward Ormston graduated from the University of Ottawa Law School in 1971. He was a Crown Prosecutor and Defence lawyer before being appointed to the Ontario Court of Justice in 1989. Justice Ormston was an initial Director of the Ontario Justice Education Network. He has been President of the Ontario Conference of Judges, past Chair of the Mental Health and Law Advisory Committee of the Mental Health Commission of Canada and is currently Chairman of the Consent and Capacity Board. Justice Ormston was appointed an "Honorary Fellow of the Law of the Future Fund" by the Canadian Bar Association in recognition of outstanding contribution to the legal profession and the advancement of law in Canada. Additionally, he has received the 2005 Pace Setter Award from the Schizophrenia Society of Canada, and has been recognized as a Champion of Mental Health by the Canadian Alliance of Mental Illness and Mental Health. In 2009, Justice Ormston was appointed to the Minister's Advisory Group on Mental Health and Addictions. Justice Ormston also received the 2011 Canadian Psychological Association Humanitarian Award and the 2012 SOAR medal for his contribution to the Ontario Administrative Justice System. Justice Ormston speaks about the intersects of Law and Mental Health across Canada and Internationally.

The Family of Psychology Keynote Address

The Family of Psychology Keynote Address
Thomas Gilovich, Ph.D.

Thomas Gilovich is Professor of Psychology at Cornell University and co-director of the Cornell Center for Behavioral Economics and Decision Research. He received his B.A. in Psychology from the University of California and his PhD in Psychology from Stanford University. His research focuses on how people evaluate information in their everyday and professional lives, and how they use that information to draw conclusions, form beliefs, and embark on courses of action. His research has been funded by the National Science Foundation and the National Institute of Mental Health. His books include *How We Know What Isn't So* (1991), *Why Smart People Make Big Money Mistakes* (1999, with Gary Belsky), *Heuristics and Biases: The Psychology of Intuitive Judgment* (2002, with Dale Griffin and Daniel Kahneman), and *Social Psychology* (2004, with Dacher Keltner and Richard Nisbett). He is a member of the American Academy of Arts and Sciences and a Fellow of the American Psychological Association, the Association for Psychological Science, the Society of Experimental Social Psychology, and the Society for Personality and Social Psychology.

Science & Applications Keynote Address

Science & Applications Keynote Address
Philip C. Kendall, Ph.D., ABPP

Philip Kendall is Laura H. Carnell Distinguished University Professor at Temple University in Philadelphia. He has been a productive researcher, scholar, and clinician, with over 450 publications, including over 30 books and over 20 treatment manuals and workbooks. His treatment programs have been translated into over a dozen languages, and he has had over 25 years of uninterrupted grant support. He placed among an elite handful of the most "Highly-Cited" individuals in the social and medical sciences. In a quantitative analysis of the faculty of the 157 APA-approved programs in clinical psychology, Dr. Kendall's citations ranked 5th. He has been a Fellow at the Center for Advanced Study in the Behavioral Sciences, won the Research Recognition Award from the Anxiety Disorders Association of America and the "Great Teacher" award from Temple University, and was identified as a "top therapist" in the tristate area by Philadelphia Magazine. Dr. Kendall's contributions include seminal work on the treatment of anxiety disorders in youth, cognitive-behavioral theory, assessment, treatment, and research methodology.

Conférenciers d'honneur

Allocution du Président d'Honneur

Président honoraire – L'honorable juge Edward Ormston

L'honorable juge Edward Ormston a reçu son diplôme de l'École de droit de l'Université d'Ottawa en 1971. Il était procureur de la Couronne et avocat de la défense avant d'être nommé à la Cour de justice de l'Ontario en 1989. Le juge Ormston a été l'un des premiers directeurs du Réseau ontarien d'éducation juridique. Il a été président de la Conférence des juges de l'Ontario, ancien président du Comité consultatif sur la santé mentale et la loi de la Commission de la santé mentale du Canada et préside actuellement la Commission du consentement et de la capacité. Le juge Ormston a été nommé « fellow honoraire du Fonds du Barreau canadien pour le droit de demain » par l'Association du Barreau canadien en reconnaissance de sa contribution exceptionnelle à la profession juridique et à l'avancement de la loi au Canada. De plus, il a reçu le prix Pace Setter 2005 de la Société de schizophrénie du Canada et a été reconnu comme un champion de la santé mentale par l'Alliance canadienne pour la maladie mentale et la santé mentale. En 2009, le juge Ormston a été nommé au Groupe consultatif ministériel de la santé mentale et de la lutte contre les dépendances. Le juge Ormston s'est vu décerné le Prix pour réalisations humanitaires de la Société canadienne de psychologie en 2011 et la médaille d'honneur de la Society of Ontario Adjudicators and Regulators (SOAR) pour sa contribution au système de justice administrative de l'Ontario. M. le juge Ormston prononce des conférences sur l'intersection de la loi et la santé mentale d'un bout à l'autre au Canada et à l'échelle internationale.

Conférence "La Famille de la Psychologie"

Conférence « La famille de la psychologie » Thomas Gilovich, Ph.D.

Thomas Gilovich est professeur de psychologie à la Cornell University et codirecteur du Cornell Center for Behavioral Economics and Decision Research. Il a obtenu un B.A. en psychologie de l'University of California et un Ph.D. en psychologie de la Stanford University. Ses travaux portent sur la façon dont les personnes évaluent l'information qu'elles recueillent dans leur vie quotidienne et professionnelle et la façon dont elles utilisent cette information pour tirer des conclusions, se forger des croyances et entreprendre des actions. Sa recherche s'est mérité l'appui financier de la National Science Foundation et la National Institute of Mental Health. Il a publié, entre autres, les ouvrages suivants : *How We Know What Isn't So* (1991), *Why Smart People Make Big Money Mistakes* (1999, en collaboration avec Gary Belsky), *Heuristics and Biases: The Psychology of Intuitive Judgment* (2002, en collaboration avec Dale Griffin et Daniel Kahneman) et *Social Psychology* (2004, en collaboration avec Dacher Keltner et Richard Nisbett). Il est membre de l'American Academy of Arts and Sciences et fellow de l'American Psychological Association, de l'Association for Psychological Science, de la Society of Experimental Social Psychology et de la Society for Personality and Social Psychology.

Conférence « Science & Application »

Conférence « Science & Application » Philip C. Kendall, Ph.D., ABPP

Philip Kendall est professeur émérite à la chaire Laura H. Carnell de la Temple University de Philadelphie. Chercheur productif, universitaire et clinicien, il a à son actif plus de 450 publications, dont plus de 30 livres, et plus de 20 guides et cahiers de traitement. Ses programmes de traitement ont été traduits dans plus de 12 langues, et il a bénéficié pendant plus de 25 ans de subventions ininterrompues. Il fait partie des quelques chercheurs les « plus fréquemment cités » dans le domaine des sciences sociales et médicales. Une analyse quantitative réalisée auprès du corps professoral des 157 programmes en psychologie clinique approuvés par l'APA a placé Dr Kendall au 5e rang, pour ce qui est du nombre de citations. Fellow du Center for Advanced Study in the Behavioral Sciences, il a remporté le Research Recognition Award de l'Anxiety Disorders Association of America et le prix « Great Teacher » de la Temple University. Il a été, en outre, désigné comme l'un des « plus grands thérapeutes » de la région des trois États (New York, New Jersey et Connecticut) par la revue Philadelphia Magazine. Ses ouvrages de référence sur le traitement des troubles anxieux chez les jeunes, la théorie cognitivo comportementale, l'évaluation et le traitement, ainsi que sur les méthodologies de recherche, sont parmi ses plus grandes contributions.

Karen R. Cohen, Ph.D., Chief Executive Officer
Lisa Votta-Bleeker, Ph.D., Deputy Chief Executive Officer and Director Science
John Service, Ph.D., Director Practice Directorate
Melissa Tiessen, Ph.D., Registrar Accreditation and Director Education Directorate

What follows is an update of science, practice and educational activity undertaken by Head Office staff and leadership since our last update in the Summer 2012 issue of Psynopsis. For any further information about any of the activities described please feel free to be in touch with us. We want to hear what you think. Unless otherwise indicated, please contact Karen Cohen (kcohen@cpa.ca) on national activities for practice. Contact Lisa Votta-Bleeker on science activity (lvottableeker@cpa.ca). Contact John Service (jcservice@cpa.ca) about provincial/territorial practice. Contact Melissa Tiessen (mtiessen@cpa.ca) on accreditation and continuing education.

Canadian Consortium of Research (CCR): The CCR met on September 24th, 2012 at which time they will address strategic planning as well as needed enhancements to communications and website. With changes to the Federal pre-budget submission process in 2012-13, CCR opted not to make a submission to the Finance Committee. CCR hopes to convene a meeting with the granting councils in fall 2012 focused on budget 2013 issues and expectations.

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Canadian Federation of the Humanities and Social Sciences (CFHSS): Following the release of its Design Discussion Document on the proposed changes to CIHR's Open Suite of Programs and Peer Review Process, CIHR has published the "What CIHR heard: Analysis of feedback on the design discussion document". CPA sat on a Blue Ribbon Panel of the CFHSS which drafted a response to CIHR's proposed suite of program changes and was invited by CFHSS to attend a meeting with CIHR President, Alain Beaudet. CIHR's report on the consultation process can be read by visiting: http://trk.cp20.com/Tracking/t.c?TizV-WcKI-1E0QM36.

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NSERC: As previously noted, from June 29th to September 28th, 2012, NSERC consulted with the research community to gather feedback on two proposed options for the future of the Research Tools and Instruments (RTI) Grants Program. In consultation with CPA's Scientific Affairs Committee, CPA wrote a letter to NSERC regarding its two proposed options and CPA's recommendations for the future of the RTI Grant Program. Visit http://www.cpa.ca/researchers/ to view the letter.

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Student Research Grants: The Canadian Psychological Association Foundation (CPAF) issued a call for Proposals over the course of the summer for student research grants. Ten applications were received; evaluations of the proposals will take place in the coming weeks. An additional call for proposals for a second disbursement will be issued in the early fall. See CPA's website for information on the successful applicants for the first disbursement, and application deadlines regarding the second disbursement: http://www.cpa.ca/researchers/

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Canadian Primary Health Care and Research Innovation Network: CPA has become a member of the Canadian Primary Health Care and Research Innovation Network. CPHCRIN is a newly established pan-Canadian research, training and policy network, composed of researchers and stakeholders in community-based primary health care (CBPHC). CPHCRIN aims to facilitate the scale-up of innovative models of CBPHC in order to improve the quality, accessibility and cost-effectiveness of primary health care in Canada.

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Opportunities for Graduate Student Placements with the CPA: In past years, and as planned for 2012-13, CPA had periodically hosted a part-time rotation for Ottawa-based doctoral interns. This year, we are glad to be able to expand this opportunity to graduate psychology students in all areas of psychology. This is an opportunity for students to participate in CPA's ongoing survey development and research, development of position papers and other communications, as well as external representation and collaboration. CPA hopes to host a graduate student (one per term) on an ongoing basis. For more information, please contact Dr. Lisa Votta-Bleeker at lvottableeker@cpa.ca or Dr. Karen Cohen at kcohen@cpa.ca

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Canadian Institute for Military and Veteran Health (CIMVH) Research Forum 2012: CPA is glad to let members know about the CIMVH Research Forum to be held on November 26-28, 2012 in Kingston, Ontario. More information about the conference can be found at http://www.cimvhr.ca/

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Psychosocial Responding during Emergencies and Disasters: In recent months, the CPA has resumed its role as co-Chair of the National Emergency Psychosocial Advisory Consortium (NEPAC). NEPAC undertook a survey of its members to identify who is doing what in the area of psychosocial responding; results from the survey will be posted on CPA's website.

The CPA has also been involved in a number of activities with the Canadian Red Cross, including meeting with staff regarding processes for psychosocial responding during an emergency, and reviewing documents related to psychological first aid for emergency responders.

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Additional Science-related Information on CPA's Website: Be sure to visit CPA's website (www.cpa.ca/researchers) regularly for new information on current funding opportunities, updates on the newly instituted Canadian Common CV, and opportunities to participate in a CPA member's research study via CPA's R2P2, just to name a few…

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International Congress of Applied Psychology (ICAP): We are glad to announce that CPA's bid to host the 2018 ICAP has been accepted in principle by the International Association of Applied Psychology. The bid was presented by Drs. Karen Cohen and David Dozois, in partnership with Mitacs (an organization dedicated to the development of research and researchers), to the IAAP (International Association of Applied Psychology) at their meeting in Cape Town South Africa in July 2012. Currently, CPA and Mitacs are working to develop a contract with the IAAP to host the 2018 congress in Montreal.

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Proposed CPA Section on Psychology and Retirement: A new CPA section has been proposed on Psychology and Retirement. For information about the section and to join, please go to http://cpa.ca/aboutcpa/cpasections/#Proposed

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Health Action Lobby (HEAL): HEAL continues to work of the Health Care Innovation Working Group (HCIWG) of the Council of the Federation http://www.councilofthefederation.ca/keyinitiatives/Healthcare.html. In her introduction to this issue of Psynopsis, focused on health service innovations, Dr. Cohen gives an update on the work of the HCIWG. Other of HEAL's activities continue to focus on the role of the federal government in Canada`s health and health care and Canada`s health human resource – these latter also relevant to the agenda of the HCIWG.

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Canadian Alliance of Mental Illness and Mental Health (CAMIMH): As mentioned in the summer 2012 issue of Psynopsis, CPA's Chief Executive Officer, Dr. Karen Cohen, is the Chair of CAMIMH's 2012 Mental Illness Awareness Week (MIAW). 2012 mental awareness activities included a Champions gala in May 2012 in Ottawa where CAMIMH had an opportunity to honour Canadians whose work and commitment advanced the cause of mental health and mental illness. MIAW itself took place the week of October 1st, 2012 and was marked by a breakfast on Parliament Hill where CAMIMH honoured the 2012 Faces of Mental Illness – Canadians with lived experience of mental illness who have come forward with their stories of recovery and messages of hope. Following the breakfast, member organizations of CAMIMH convened 25 meetings with Parliamentarians and Senators to discuss gaps and opportunities for Canada's mental health. A key CAMIMH message, in concert with CPA's own message, is a need for enhanced access to services and supports. The media coverage included CPA's CEO hosting a press conference on Parliament Hill as well as an appearance on Canada AM in her role as the 2012 MIAW Chair. Visit CPA's website for links to MIAW information and updates and visit MIAW at http://camimh.ca/mental-illness-awareness-week-english/about-miaw/

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Mental Health Commission of Canada (MHCC): In May 2012, CPA attended the launch of the MHCC's mental health strategy for Canada ***Changing Directions, Changing Lives*** http://strategy.mentalhealthcommission.ca/. CPA had provided written feedback into earlier iterations of the strategy and issued a news release at it launch http://cpa.ca/docs/file/CAMIMH/MHCCstrategy2012_CPAfinal_ENFR.pdf See Dr. Stockdale-Winder's article this issue for more information about the strategy.

Other Advocacy activity

Summer 2012 has not been silent on the advocacy front for CPA. CPA senior staff convened meetings with the Department of National Defence with a focus on needs for psychological services, recruitment and retention of psychologists and clinical training opportunities at DND along with other federal departments. Senior staff has consulted with a number of members with expertise and experience in military health and welcome further input. For more information, contact Dr. Karen Cohen at kcohen@cpa.ca Further, CPA issued a press release in September 2012 in response to the federal government's announcement of more funding for mental health in the military. The release, which had significant media pick up, can be found at http://cpa.ca/docs/file/Press%20Release/PressReleaseDND_Sep12_2012.pdf

In August 2012, CPA successfully retained a group of health economist consultants commissioned to develop a business model for enhanced access to psychological services in Canada. Although we know well that psychological treatments are effective interventions of choice for the mental health conditions affecting Canadians, what we have not been able to do before now is suggest how Canadian jurisdictions might finance better

access to service. The consultants' report is due in early 2013 and will become a cornerstone document in CPA's work with funders and stakeholders in health and mental health. Watch the website for progress reports and proceedings.

As mentioned in the summer issue, CPA submitted a 2013 pre-budget brief to the federal government in which we offered a number of solutions for Canada's mental health. The submission can be found at http://cpa.ca/docs/file/CPA_Submission_2012_PreBudgetConsultation.pdf

Although not nearly all submissions will lead to invitations to appear before the government's Finance Committee, our submission none-the-less gives us a platform from which to continue our federal advocacy work for science and practice.

Also in summer 2012, CPA was pleased to support the advocacy activities of several Canadian jurisdictions. These included joining APNS in meeting with government on matters related to psychological services, supporting the visit of the psychologist-family physician team of Drs. Jean Grenier and Marie-Helene Chomienne, in a visit with MPS and the Manitoban government where there is keen interest in enhancing access to psychological services, and joining BCPA in a meeting with elected officials focused on integrating psychologists into primary collaborative care. In October 2012, we assisted our colleagues in New Brunswick in a meeting with government around entry to practice standards. CPA and its Board are committed to supporting jurisdictions via its Directorates as well as through Head Office resources in local advocacy opportunity. For more information, please contact Dr. Cohen at kcohen@cpa.ca

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Psynopsis: Psynopsis' theme for **Winter 2013 is advocacy, Spring 2013 is aging, Summer 2013 is e-health and Fall 2013 is military and veteran health**. Submissions are enthusiastically invited. Send 900 words or less to Tyler Stacey-Holmes at styler@cpa.ca (Fall by September 1st, Winter by December 1st, Spring by March 1st and Summer by June 15th). If you have ideas for Psynopsis themes, please contact kcohen@cpa.ca

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Practice Directorate (PD): Activity among Canada's jurisdictions : A review of PD activity is below. For more information on the Practice Directorate, please go to the CPA web site at http://www.cpa.ca/practitioners/practicedirectorate/.

National Advocacy Campaign. The National Advocacy Campaign took off in earnest in September, 2012. It is designed to have common advocacy points and language used in each jurisdiction at the same time to increase advocacy impact. The general advocacy message is increasing access to psychological services for mental and behavioural health problems and conditions. More specific materials have been developed that focus on increasing services in the areas of: a) primary care; b) children, youth, and young adults; and c) medically unexplained symptoms.

Doctoral Standard across Canada: A Clear Majority. There were a number of exciting initiatives coming from the Practice Directorate meeting in June. One of these events was the passing of the motion **"The CPA Practice Directorate supports the doctoral degree as the national educational standard for the licensing of psychologists in Canada."** While support for the doctoral degree has long been the policy of CPA, CPA itself posted an articulated position on entry to practice in 2012 http://cpa.ca/practitioners/resourcesofinterest/. This was a new direction for a number of the provincial/territorial associations, and several spent a great deal of time over the past 6 months consulting and discussing this issue with their members. Dr. John Service, Director of the Practice Directorate, assisted a number of associations by presenting at their town hall meetings on this issue. Although the Practice Directorate motion did not pass unanimously, (Saskatchewan, Newfoundland and Northwest Territories voted against), the passing of this motion clearly provides meaningful support for those remaining associations to move towards the doctoral standard. It also provides a context for the regulatory bodies and governments in Canada on the issue. The feeling in the room during the Practice Directorate meeting was that this was an important event which will provide a positive influence on the future development of our profession.

Search for a Director. Practice Directorate Director, Dr. John Service, will be completing his three year contract with the PD at the end of December, 2012. CPA has posted the job. The deadline for applications was September 30th, 2012.

Supply, Demand and Need of Psychologists in Canada. There was a general consensus that there is a psychology supply problem in Canada save for perhaps Quebec and Alberta. All provincial/territorial associations agreed to bring data or the considered opinion of their associations to the January 2013 PD meeting to further this discussion. CPA has struck a steering committee that includes CPA senior staff, CPA Committee on Professional Affairs, the Directorates of Practice, Science, and Education, as well as other relevant psychology groups to organize a Summit in 2013 to address supply, demand and need for research and practice in psychology. The Practice Directorate is looking forward to supporting and profiting from the work of the CPA Steering Committee and the Summit.

Inclusion of Psychology in Publicly Funded Services in Canada. There is a perceived general dearth of psychologists in publicly funded services in Canada. Provincial/territorial associations agreed to discuss the issue at their Board level in anticipation of a more full discussion in January, 2013.

RxP in Canada. The delegates from each provincial/territorial association agreed to come to the next meeting prepared to discuss what steps if any their association has taken in regards to prescription privileges and what steps they envision taking, if any, within the next five years.

Custody and Access Issues in Canada. Access to psychological assessments and their use in custody and access decisions as well as in other areas such as motor vehicle accidents and workers injury and rehabilitation are often the focus of legal and regulatory actions themselves. The Practice Directorate agreed to gather data from the CPA/CPAP insurance program in order to promote a more thorough discussion on the issue at the January 2013 PD meeting. These types of complaints are by far the most prevalent in terms of insurance claims. They are common for regulatory bodies as well.

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Accreditation: The CPA Accreditation Office is pleased to finally announce the launch of our online reporting system. This site can be used for either an annual report or self-study submission, and can be accessed year-round. The system has been designed to be easy to follow, and parallels the traditional paper versions of the annual report and self-study forms. Programmes due this year for an annual report or self-study have already been sent instructions for accessing the site. For any new programme wishing to submit an initial self-study application, please contact the CPA Accreditation Office at accreditation@cpa.ca We also welcome programmes to be in touch with any feedback we can use to improve future versions of the online system.

Thank you to our Site Visitors! The CPA Accreditation Panel wishes to offer our sincere appreciation to all the psychologists who have contributed their time and expertise to act as site visitors in the 2011-2012 academic year. A huge thank you goes to Drs:

Claude Bélanger
Clarissa Bush
Janice Cohen
Pamela Cooper
Anna-Beth Doyle
Paul Greenman
Peter Henderson
Charlotte Johnston
Catherine Lee
Patricia Minnes
John Pearce
Donald Saklofske
Michael Vallis
Lauren Weitzman
Marc-André Bouchard
Linda Caterino
Jennifer Connolly
Deborah Dobson
Sheryl Green
Kellie Hadden
Timothy Hogan
Jane Ledingham
Robert McIlwraith
Kerry Mothersill
Teréz Rétfalvi
Dale Stack
Carl von Baeyer

Karen R. Cohen, Ph.D., chef de la direction
Lisa Votta-Bleeker, Ph.D., adjointe à la chef de la direction et directrice, Direction générale de la science
John Service, Ph.D., directeur, Direction générale de la pratique
Melissa Tiessen, Ph.D., registraire de l'agrément et directrice, Direction générale de l'éducation

Ce qui suit représente une mise à jour des activités en science, en pratique et en éducation mises de l'avant par le personnel du siège social et la direction depuis notre dernière mise à jour dans le numéro d'été 2012 de Psynopsis. Pour tout autre renseignement au sujet des activités décrites n'hésitez pas à communiquer avec nous. Nous sommes toujours intéressés à entendre ce que vous pensez. À moins d'indication contraire, veuillez communiquer avec Karen Cohen (kcohen@cpa.ca) au sujet des activités à l'échelle nationale qui concernent la science et la pratique. Communiquez avec Lisa Votta-Bleeker au sujet des activités en science (lvottableeker@cpa.ca). Communiquez avec John Service (jcservice@cpa.ca) au sujet des activités liées à la pratique à l'échelle provinciale ou territoriale. Communiquez avec Melissa Tiessen (mtiessen@cpa.ca) pour toute question relative à l'agrément et l'éducation permanente.

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Consortium canadien pour la recherche (CCR): La prochaine réunion du CCR a eu lieu le 24 septembre 2012 où il sera question de planification stratégique ainsi que les améliorations nécessaires aux communications et au site Web. Compte tenu des changements au processus de présentation prébudgétaire du gouvernement fédéral en 2012-2013, le CCR a décidé de ne pas faire de présentation au Comité sénatorial permanent des finances. Le CCR entend convoquer une réunion avec les conseils subventionnaires à l'automne de 2012 qui sera axée sur les enjeux et les attentes du budget 2013.

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Fédération canadienne des sciences humaines (FCSH): Après la publication de son document de travail conceptuel sur les propositions de changements à la série de programmes ouverts des IRSC et d'améliorations au processus d'évaluation par les pairs, les IRSC ont publié « Les IRSC à votre écoute : analyse de la rétroaction sur le document de travail conceptuel ». La SCP a siégé à la table du groupe d'experts de la FCSH qui a ébauché une réponse aux changements apportés à l'éventail ouvert de programmes de financement des IRSC et a été invitée par la FCSH à assister à une réunion avec le président des IRSC, Alain Beaudet. Le rapport des IRSC sur le processus de consultation se trouve à l'adresse http://trk.cp20.com/Tracking/t.c?TizV-WcKI-1E0QM36http://www.cihr-irsc.gc.ca/f/44761.html.

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CRSNG: Comme indiqué précédemment, du 29 juin au 28 septembre 2012, le CRSNG a consulté la communauté de la recherche pour obtenir une rétroaction sur deux options proposées pour l'avenir du programme de subventions d'Outils et d'instruments de recherche (OIR). En consultation avec son Comité des affaires scientifiques, la SCP a rédigé une lettre au CRSNG concernant ses deux options proposées et les recommandations de la SCP quant à l'avenir du programme de subventions d'OIR. Rendez-vous au site http://www.cpa.ca/researchers/ pour voir la lettre.

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Bourses de de recherche pour les étudiants: La Fondation de la Société canadienne de psychologie (FSCP) a publié un appel de propositions au cours de l'été pour des propositions de recherche par des étudiants. Dix demandes ont été reçues; les évaluations des propositions auront lieu au cours des prochaines semaines. Un appel de propositions additionnel pour un deuxième déboursement sera émis au début de l'automne. Reportez-vous au site Web de la SCP pour obtenir de l'information sur les demandes retenues pour le premier déboursement, et les dates limites de demande pour le deuxième déboursement : http://www.cpa.ca/researchers/

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Réseau canadien de recherche et innovation en soins de santé primaires (RCRISSP): La SCP est devenue membre du Réseau canadien de recherche et innovation en soins de santé primaires. Le RCRISSP est un réseau de recherche, de formation et de politique pancanadien nouvellement mis sur pied, constitué de chercheurs et d'intervenants dans le domaine des soins de santé primaires communautaires (SSPC). Le RCRISSP vise à faciliter l'accroissement de modèles innovateurs des SSPC afin d'améliorer la qualité, l'accessibilité et le coût-efficacité des soins de santé primaires au Canada.

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Occasions de placements d'étudiants diplômés auprès de la SCP: Au cours des années passées, et comme nous le planifions pour 2012-2013, la SCP a périodiquement pu accueillir dans ses bureaux d'Ottawa des stages pour des étudiants au doctorat. Cette année, nous sommes heureux d'être en mesure de renouveler l'expérience pour les étudiants diplômés dans tous les domaines de la psychologie. C'est une occasion pour les étudiants de participer à l'élaboration d'enquêtes et de faire de la recherche, tout en aidant à la préparation d'exposés de position et autres communications. Ils pourraient aussi être amenés à faire de représentations et favoriser la collaboration à l'externe. La SCP espère accueillir un étudiant diplômé (un par semestre) sur une base continue. Pour plus d'information, veuillez communiquer avec D^re^ Lisa Votta-Bleeker à l'adresse lvotta-bleeker@cpa.ca ou D^re^ Karen Cohen à l'adresse kcohen@cpa.ca

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Forum de recherche de l'Institut canadien de recherche sur la santé des militaires et des vétérans (ICRSMV) 2012

La SCP a le plaisir d'annoncer à ses membres la tenue du forum de recherche de l'ICRSMV qui aura lieu du 26 au 28 novembre 2012 à Kingston, en Ontario. Vous pourrez trouver plus d'information au sujet de la conférence à l'adresse http://www.cimvhr.ca/

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Intervention psychosociale dans les situations d'urgences et de désastres: Au cours des derniers mois, la SCP a repris son rôle de coprésident du National Emergency Psychosocial Advisory Consortium (NEPAC). NEPAC a fait un sondage auprès de ses membres afin de déterminer qui fait quoi dans le domaine des interventions psychosociales; les résultats du sondage seront publiés sur le site Web de la SCP.

La SCP s'est également engagée dans un certain nombre d'activités auprès de la Croix-Rouge canadienne, notamment la rencontre du personnel au sujet des processus d'interventions psychosociales en situation d'urgence, et l'examen des documents relatifs aux premiers soins psychologiques des intervenants dans le cas d'une urgence.

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Information additionnelle liée à la science sur le site Web de la SCP: Assurez-vous de visiter le site Web de la SCP (www.cpa.ca/researchers) régulièrement pour obtenir de l'information sur les occasions de financement actuelles, les mises à jour du CV commun canadien nouvellement institué et les occasions de participer aux études de recherche des membres de la SCP par le biais du site PRPR de la SCP, pour ne nommer que ceux-ci.

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Congrès international de psychologie appliquée (CIPA): Il nous fait plaisir d'annoncer que la proposition de la SCP d'accueillir le CIPA 2018 a été acceptée en principe par l'International Association of Applied Psychology. La proposition a été présentée par Drs Karen Cohen et David Dozois, en partenariat avec Mitacs (une organisation spécialisée dans le développement de la recherche et des chercheurs), à l'IAAP (International Association of Applied Psychology) à son congrès de Cape Town, en Afrique du Sud, en juillet 2012. Actuellement, la SCP et Mitacs travaillent à la rédaction d'un contrat avec l'IAAP pour accueillir le congrès de 2018 à Montréal.

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Section sur la psychologie et la retraite proposée par la SCP: Une nouvelle section de la SCP a été proposée sur la psychologie et la retraite. Pour plus d'information au sujet de la section et pour y adhérer, veuillez vous rendre à l'adresse http://cpa.ca/aboutcpa/cpasections/#Proposed

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Groupe Action santé (HEAL): HEAL continue de travailler avec le Groupe de travail sur l'innovation en matière de santé (GTIMS) du Conseil de la fédération http://www.councilofthefederation.ca/keyinitiatives/Healthcare.html. Dans son introduction dans le numéro actuel de Psynopsis sur les innovations dans le service de santé, Dre Cohen a fait une mise à jour du travail du GTIMS. Les autres activités du groupe HEAL continuent de cibler le rôle du gouvernement fédéral dans la santé et les soins de santé du Canada et les ressources humaines en santé – ces dernières sont également pertinentes au programme du GTIMS.

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Alliance canadienne pour la maladie mentale et la santé mentale (ACMMSM): Comme mentionné dans le numéro de l'été 2012 de Psynopsis, la chef de la direction de la SCP, Dre Karen Cohen, est la présidente de la Semaine de sensibilisation aux maladies mentales (SSMM) organisée par l'ACMMSM en 2012. Dans le cadre des activités de sensibilisation à la santé mentale de 2012 le gala des champions a eu lieu en mai 2012 à Ottawa où l'ACMMSM a eu l'occasion d'honorer les Canadiens dont le travail et l'engagement ont fait progresser la cause de la santé mentale et de la maladie mentale. La SSMM proprement dit a eu lieu au cours de la semaine du 1er octobre 2012 et a été soulignée par un déjeuner sur la Colline parlementaire où l'ACMMSM a célébré les « Visages de la santé mentale en 2012 – Des Canadiens qui ont vécu l'expérience de la maladie mentale et qui ont fait part de leurs anecdotes et de messages d'espoir. À la suite du déjeuner, les organisations membres de l'ACMMSM planifient des réunions avec des députés afin de discuter des lacunes et des occasions pour la santé mentale au Canada. La nécessité d'améliorer l'accès aux services et aux services de soutien demeure un message clé de l'ACMMSM, comme celui de la SCP. Nous prévoyons que la couverture médiatique sera aussi importante qu'elle était lors du gala de mai 2012. Rendez-vous au site Web de la SCP pour les dernières nouvelles de la SSMM et rendez-vous au site de la SSMM à l'adresse http://fr-ca.camimh.ca/

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Commission de la santé mentale du Canada (CSMC): En mai 2012, la SCP a assisté au lancement de la stratégie en santé mentale de la CSMC ***Changer les orientations, changer des vies*** http://strategy.mentalhealthcommission.ca/. La SCP a fourni une rétroaction écrite dans les versions ultérieures de la stratégie et publié un communiqué à son lancement http://cpa.ca/docs/file/CAMIMH/MHCCstrategy2012_CPAfinal_ENFR.pdf. Reportez-vous à l'article de Dr Stockdale-Winder dans ce numéro pour plus d'information au sujet de la stratégie.

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Autres activités de représentation

La SCP n'a pas chômée sur le plan de la représentation au cours de l'été 2012. La direction de la SCP a convoqué des réunions avec le ministère de la Défense nationale au sujet des besoins de services de psychologie, de recrutement et de maintien en poste des psychologues et des occasions de formation clinique au MDN ainsi qu'à d'autres ministères du gouvernement fédéral. La haute direction a consulté un certain nombre de membres possédant des compétences et de l'expérience dans le domaine de la santé des militaires et a demandé plus de rétroaction. Pour plus d'information, communiquez avec Dre Karen Cohen à l'adresse kcohen@cpa.ca En outre, la SCP a émis un communiqué de presse en septembre 2012 en réponse à l'annonce du gouvernement fédéral d'un financement accru pour la santé mentale dans le domaine militaire. Le communiqué de presse, qui a suscité de façon importante l'attention des médias, se trouve à l'adresse http://cpa.ca/docs/file/Press%20Release/PressReleaseDND_Sep12_2012.pdf

En août 2012, la SCP a réussi à retenir les services d'un groupe d'économistes consultants dans le domaine de la santé dans le but d'élaborer un modèle d'affaires visant à améliorer l'accès aux services de psychologie au Canada. Même si nous savons très bien que les traitements de psychologie sont des interventions efficaces de choix pour les conditions de santé mentale qui influencent les Canadiens, nous n'avions pas jusqu'ici été en mesure de suggérer comment les administrations canadiennes pourraient financer un meilleur accès au service. Le rapport des consultants devrait paraître au début de 2013 et deviendra un document d'appui pour le travail de la SCP auprès des bailleurs de fonds et des intervenants dans le domaine de la santé et de la santé mentale. Reportez-vous au site Web pour les rapports d'avancement et les comptes rendus.

Comme mentionné dans le numéro d'été, la SCP a fait une présentation prébudgétaire de 2013 au gouvernement fédéral dans laquelle nous avons proposé un certain nombre de solutions pour la santé mentale au Canada. Cette présentation se trouve à l'adresse http://cpa.ca/docs/file/CPA_Submission_2012_PreBudgetConsultation.pdf

Même si les présentations ne mèneront pas toutes à des invitations à se présenter devant le Comité des finances du gouvernement, notre présentation nous a néanmoins donné une plateforme à partir de laquelle nous pourrons poursuivre nos activités de représentation auprès du gouvernement fédéral pour la science et la pratique.

Aussi au cours de l'été de 2012, la SCP a eu le plaisir d'appuyer les activités de représentation de plusieurs administrations canadiennes. Nous avons entre autres accompagné l'APNS à une réunion avec le gouvernement sur des questions liées aux services de psychologie. Nous avons aussi appuyé la visite de l'équipe de médecin et psychologue de familles, Drs Jean Grenier et Marie-Hélène Chomienne, à la MPS lors de sa rencontre avec des représentants du gouvernement manitobain qui s'intéresse grandement à l'amélioration de l'accès aux services de psychologie. Nous avons aussi participé à une réunion de la BCPA avec des représentants élus; cette réunion était axée sur l'intégration des psychologues dans la prestation des soins primaires en collaboration. En octobre 2012, nous avons accompagner nos collègues du Nouveau-Brunswick à l'occasion d'une réunion avec les représentants gouvernementaux portant sur les normes d'admission dans la pratique. La SCP et son conseil d'administration se sont engagés à appuyer les administrations par ses directions ainsi que par les ressources du siège social pour ce qui est des possibilités de représentation. Pour plus d'information, veuillez communiquer avec Dre Cohen à l'adresse kcohen@cpa.ca

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Psynopsis: Le thème du **numéro d'hiver 2013 de Psynopsis est la représentation, celui du numéro de printemps 2013 est le vieillissement, celui du numéro d'été 2013 est la cybersanté et celui de l'automne 2013 est la santé des militaires et des anciens combattants**. Les articles seront fort bien accueillis. Faites parvenir 900 mots ou moins à Tyler Stacey-Holmes à l'adresse styler@cpa.ca (avant le 1er septembre pour le numéro d'automne, le 1er décembre pour celui d'hiver, le 1er mars pour celui du printemps et le 15 juin pour le numéro d'été). Si vous avez des idées pour des thèmes à aborder dans Psynopsis, veuillez communiquer avec kcohen@cpa.ca

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Direction générale de la pratique (DGP) : activités dans les administrations canadiennes: Vous trouverez ci-dessous un survol des activités de la DGP. Pour plus d'information sur la Direction générale de la pratique, veuillez vous rendre au site Web de la SCP à l'adresse http://www.cpa.ca/practitioners/practicedirectorate/.

Campagne de représentation nationale. La campagne de représentation nationale a véritablement démarré en septembre 2012. Elle est conçue pour se doter de points et d'une langue de représentation communs utilisés dans chaque administration en même temps afin d'accroître l'incidence des activités de représentation. Le message de représentation général est d'accroître l'accès aux services de psychologie pour les problèmes et les conditions de santé mentale et comportementale. Du matériel plus ciblé axé sur l'augmentation des services dans les domaines des : a) soins primaires, b) des enfants, des jeunes et des jeunes adultes et c) des symptômes inexpliqués par la médecine a été élaboré.

Norme doctorale au Canada : une majorité claire. Il y a eu un bon nombre d'initiatives emballantes mis de l'avant à la réunion de la Direction générale de la pratique en juin. L'un de ces événements consistait à passer la motion suivante : **« La Direction générale de la pratique de la SCP appuie le diplôme de doctorat comme norme d'éducation nationale pour l'octroi d'un permis d'exercer aux psychologues au Canada. »** Même si la politique de la SCP préconise depuis

longtemps le doctorat, nous avons publié une position articulée sur les normes d'admission à la profession de psychologue en 2012 http://cpa.ca/practitioners/resourcesofinterest/. Il s'agissait d'une nouvelle orientation pour un certain nombre d'associations provinciales et territoriales, et plusieurs d'entre elles ont passé beaucoup de temps au cours des six derniers mois à consulter et à discuter de cette question avec leurs membres. Dr John Service, directeur de la Direction générale de la pratique, a aidé un bon nombre des associations en faisant une présentation à des rencontres de discussion ouverte sur cette question. Même si la motion de la Direction générale de la pratique n'a pas été adoptée à l'unanimité, (la Saskatchewan, Terre-Neuve et les Territoires du Nord-Ouest ne l'ont pas entérinée), cette motion assure sans ambiguïté un soutien important aux autres associations désireuses d'adopter la norme du doctorat dans leur administration. Cette norme établit dresse aussi un contexte pour les organismes réglementaires et les gouvernements au Canada sur cette question. Le sentiment dans la salle au cours de la réunion de la Direction générale de la pratique était qu'il s'agissait d'un événement important qui aura une influence positive pour l'essor futur de notre profession.

Poste de directeur à combler. Le mandat de trois ans du directeur de la Direction générale de la pratique, Dr John Service, prend fin en décembre 2012. La SCP a publié l'offre d'emploi. La date limite pour faire parvenir les demandes était le 30 septembre 2012.

Offre, demande et besoin de psychologues au Canada. Il y a consensus général à savoir qu'il y a un problème d'offre en psychologie au Canada sauf peut-être au Québec et en Alberta. Toutes les associations provinciales/territoriales ont accepté d'apporter leurs données ou de faire valoir l'opinion éclairée de leurs associations à la réunion de la DGP de janvier 2013 afin de pouvoir approfondir cette discussion. La SCP a mis sur pied un comité de direction qui inclut le personnel-cadre de la SCP, le Comité des affaires professionnelles de la SCP, les Directions générales de la pratique, de la science et de l'éducation, ainsi que d'autres groupes de psychologie pertinents pour organiser un sommet en 2013 qui examinera les questions de l'offre, de la demande et du besoin de recherche et de pratique en psychologie. La Direction générale de la pratique entend bien soutenir le travail du Comité de direction de la SCP et du sommet et en profiter.

Inclusion de la psychologie dans les services financés par les deniers publics au Canada. Il y a une pénurie générale évidente de psychologues dans les services financés par les deniers publics au Canada. Les associations provinciales/territoriales ont convenu de discuter de cet enjeu au niveau de leur conseil d'administration en attendant une discussion plus approfondie en janvier 2013.

Pouvoir d'ordonnance au Canada. Les délégués de chacune des associations provinciales/territoriales ont convenu de venir à la prochaine réunion préparés à discuter les étapes qu'auraient prises certaines associations à l'égard des privilèges d'ordonnance et les étapes qu'ils envisagent prendre, le cas échéant, au cours des cinq prochaines années.

Problèmes de garde et d'accès au Canada. L'accès aux évaluations psychologiques et leur utilisation dans les décisions en matière de garde et de droit de visite ainsi que dans d'autres domaines comme les accidents de la route, les accidents de travail et les cas de réadaptation de la personne sont souvent le point centrale des mesures juridiques et réglementaires. La Direction générale de la pratique a convenu de recueillir des données du régime d'assurance de la SCP/CSPP afin de favoriser une discussion plus approfondie de la question lors de la réunion de la DGP de janvier 2013. Ces types de plaintes sont de loin les plus fréquentes au chapitre des réclamations d'assurance. Elles sont aussi communes pour les organismes réglementaires.

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Agrément: Le bureau d'agrément de la SCP a le plaisir d'annoncer finalement le lancement de son système de rapport en ligne. Ce site peut être utilisé soit pour un rapport annuel ou une autoévaluation et il est possible d'y accéder à longueur d'année. Le système a été conçu pour être convivial et imite les versions imprimées traditionnelles du rapport annuel et des formulaires d'autoévaluation. Les programmes qui doivent présenter un rapport annuel ou une autoévaluation cette année ont déjà reçu les instructions sur la façon d'accéder au site. Pour tout nouveau programme qui veut présenter une demande d'autoévaluation initiale, veuillez communiquer avec le bureau d'agrément de la SCP à accreditation@cpa.ca Nous invitons aussi les programmes à nous faire parvenir leur rétroaction que nous pourrons utiliser pour améliorer les versions futures du système en ligne.

Un grand merci à nos visiteurs d'installations! Le jury d'agrément de la SCP tient à adresser ses sincères remerciements à tous les psychologues qui ont contribué de leur temps et de leurs compétences pour agir à titre de visiteurs d'installation au cours de l'année universitaire 2011-2012. Un grand merci aux Drs : Claude Bélanger, Marc-André Bouchard, Clarissa Bush, Linda Caterino, Janice Cohen, Jennifer Connolly, Pamela Cooper, Deborah Dobson, Anna-Beth Doyle, Sheryl Green, Paul Greenman, Kellie Hadden, Peter Henderson, Timothy Hogan, Charlotte Johnston, Jane Ledingham, Catherine Lee, Robert McIlwraith, Patricia Minnes, Kerry Mothersill, John Pearce, Teréz Rétfalvi, Donald Saklofske, Dale Stack, Michael Vallis, Carl von Baeyer and Lauren Weitzman

South African International Conferences 2012

Janel Gauthier, Ph.D., Chair and John Berry, Ph.D., Secretary
International Relations Committee

Two major international conferences were held in South Africa in July 2012. The following provides a brief overview of them.

The 30th International Congress of Psychology

The 2012 International Congress of Psychology (ICP) was organised by the National Research Foundation and the Psychological Society of South Africa (PsySSA) under the auspices of the International Union of Psychological Science (IUPsyS). Held at the Cape Town International Convention Centre form the 22nd to the 27th of July 2012, it was the first ICP to be held on African soil in a 123-year history of ICPs (the first ICP was held in Paris in 1889). As it attracted more than 5,800 delegates from 103 different countries, including 134 from Canada, it was also the most representative international event in psychology ever. The theme of the ICP 2012 was "Psychology serving the humanity".

An extensive and rich scientific programme was offered to registrants over the five-day conference. It should be noted that the 2012 ICP Organising Committee received a total of 7,151 abstracts, which were reviewed by 44 topic committees comprising international experts. As a result of these reviews, 30% of the submissions were rejected, and 262 of them were re-submitted with suggested changes.

Presentations ranged from expert lectures and symposia through lively debates and panel discussions to award lectures, translational policy research seminars, workshops and a large array of traditional and electronic posters. There were 14 invited workshops, 107 invited symposia and 133 invited addresses (including keynote addresses and state-of-the science lectures). Canada was strongly represented among the invited speakers as 29 of the invited addresses were presented by Canadian psychologists.

One of the highlights of ICP 2012 was the Opening Ceremony. It kicked off with the United Nations High Commissioner for Human Rights, Dr. Navi Pillay, giving the Keynote Address; Archbishop Emeritus Desmond Tutu receiving the Steve Biko Award for Psychological Liberation (from the Steve Biko Foundation and the PsySSA); and Noel Chabani Manganyi (1st Director-General of Education under Nelson Mandela) receiving a PsySSA Fellowship.

Opening ceremony of the International Congress of Psychology in Cape Town, July 2012: Dr. Navi Pillay (on right), United Nations High Commissioner for Human Rights, receiving an award

Another highlight of ICP 2012 was the lecture presented by Professor Emeritus Albert Bandura who was honoured at the ICP 2012 for his lifetime achievement. Professor Bandura's contributions to psychological science are amongst the most significant in the field. Besides Sigmund Freud, B. F. Skinner and Jean Piaget, he is the fourth most cited psychologist of the 20th Century and the most cited living one (source: Review of General Psychology, 2002, vol. 6, No. 2, 139-152). Bandura was born in 1925 in northern Alberta, Canada. Because he was unable to travel due to health reasons, his lecture was recorded at Stanford University and played when he was scheduled to receive the IUPsyS 2012 Lifetime Career Award. The award was accepted on his behalf by his designate Janel Gauthier.

In his concluding remarks at the end of the 2012 Congress, Rainer K. Silbereisen said "The presentations and discussions here in Cape Town are the fertilizer and catalysts for better and more relevant basic, applied, and translational research, and for the professional applications of psychology – all working towards improving, developing and enriching society for everyone. Psychology is serving the humanity".

The ICP 2012 has already begun to influence psychology in Africa. The African countries present at the conference adopted the Cape Town Declaration on the 22nd of July, and created the Pan African Psychological Union.

The next ICP will be held at the Pacifico Yokohama Convention Centre in Yokohama, Japan, from July 24 to 29, 2016.

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Highlights of the 22nd Biennial Meeting of the International Society for the Study of Behavioral Development

From left: Nancy Galambos (Chair of ISSBD 2012 Local Organizing Committee), Jeff Bisanz (Vice-Chair), Lisa Strohschein (Vice-Chair), Barb Robinson (University of Alberta conference management co-ordinator)

Kimberly A. Noels, Ph.D., University of Alberta
Member of the CPA International Relations Committee and Member of the ISSBD Local Organizing Committee

From July 8 through 12, the University of Alberta hosted the 22nd Biennial Meeting of the International Society for the Study of Behavioral Development (ISSBD) in Edmonton, AB (see http://www.issbd2012.com/). ISSBD is a society that promotes scientific research of human development throughout the lifespan and includes members across many scientific disciplines from around the globe (http://www.issbd.org/Home.aspx).

The 2012 conference drew almost 900 delegates from over 50 countries on 6 continents (of which almost a third were Canadian researchers), coming primarily from psychology, but also human ecology, sociology, and rehabilitation medicine. As stated by Nancy Galambos, Chair of the Local Organizing Committee, "the goal of ISSBD 2012 was to reinforce and foster scholarly exchange on a diversity of developmental topics, and to promote the development of international contacts and collaborations. We believe that this goal was achieved".

The scientific program was indeed diverse in terms of both the topics and the nations and cultures represented. The poster sessions and workshops, symposia and invited addresses covered issues relevant to different segments of the lifespan, such as parenting, social development, mental health, school, neighborhood and community influences, and biological processes and physical health. Keynote speakers included Kaarin Anstey from the Australian National University who discussed cognitive development and decline over the lifespan; Jeanne Brooks-Gunn of Columbia University, who spoke about the impact of families and neighborhoods on development; Michael Meaney from McGill University, who described his research on the parental regulation of the structure and function of the genome

Continued on page 47

Biennial Meeting

Continued from page 46

in the offspring; and Ellen Bialystok from York University, who looked at bilingual development and cognitive ability.

Invited addresses from researchers in Chile, China, Finland, Germany, Israel, Japan and the USA covered topics ranging from motivation and co-regulation during critical life-span transitions to cross-cultural communalities in parent-adolescent relationships in different societies to creating a more global understanding of behavioral development through the metaphor of domestication.

Nine invited symposia were convened by co-chairs from Australia, Belgium, Canada, Germany, Hong Kong, Netherlands, South Africa and the USA. These explored themes such as the self and the social construction of aging; understanding popularity in the peer system; health and cognition in older populations; independence, love and work in the transition to adulthood; and the interface between cultural continuity and prevention interventions with First Nation and Native American youth.

The conference was also noteworthy because of the strong representation of early career scholars (i.e., those who are working on a degree or within 7 years post-PhD). They comprised 45% of the delegates, and many more students were co-investigators on the research presented. Over 40% of the Canadian researchers were early career scholars, and additionally well over 100 student volunteers received a short-term pass to the conference in exchange for their contribution. The program included several events targeted specifically to newer researchers, including a reception and four in-conference professional development workshops, as well as travel support for several presenters. It is hoped that this conference will be an important milestone in the careers of these emerging scholars.

Sponsors for the conference included a variety of university, government and corporate sponsors, including CPA. This meeting was not only an important occasion for Canadian developmental psychologists to gather together, it was also an important showcase for Canadian researchers to present their work to scholars outside Canada.

The next biennial meeting of ISSBD will be hosted by East China Normal University in Shanghai, China from July 8 to 11, 2014 (http://www.issbd2014.com/).

International Conferences

Continued from page 45

The 21st International Congress of Cross-Cultural Psychology

The 21st International Congress of the International Association for Cross-Cultural Psychology (IACCP) was held at the University of Stellenbosch, South Africa, on the occasion of the 40th anniversary of the Association, from the 17th to the 21st of July 2012. It was organized jointly by Prof. Deon Meiring (University of Pretoria & University of Stellenbosch), and Prof. Leon Jackson (University of Johannesburg).

The conference theme was "Nurturing Diversity for Sustainable Development". This was the first international conference of the IACCP to be held in Africa, making the theme particularly relevant to the needs of this region. There were 560 participants from 68 countries, with the largest number from South Africa (with 109 participants), followed by those from the USA (with 48), the UK (with 28), the Netherlands (with 33) and Canada (with 17). Topics included acculturation, personality, cognition, child development, emotions, cultural change, prejudice, racism, discrimination and stereotyping, clinical psychology, gender issues, indigenous psychology, cross-cultural methods and assessment, ethnicity and identity, health and well-being, intercultural interactions, intergroup relations, and industrial/organisational psychology. These topics were addressed by 10 keynote speakers, in 12 invited symposia, and in hundreds of oral papers and posters.

One of the goals of the IACCP is to build research capacity among young scholars from developing countries. In pursuit of this goal, the academic programme included four workshops: Development and Adaptation of Psychological Tests and Scales for Use in Health and Education Related Fields; Emotion Assessment in Diverse Contexts; A Beginner's Guide to Structural Equation Modelling; and An Introduction to Cross-Cultural Psychology. In addition, four winter school sessions were offered: Culture and Individual Development; Culture, Work and Organizations; Culture, Well-being and Societal Development; and Acculturation and Intercultural Relations.

The IACCP prides itself on being open, and welcoming to everyone, and on providing opportunities for mentoring and for the development of research collaboration. The academic and social programmes were extremely rich and varied, bringing together younger and older scholars from around the world. This combination of intense academic and social activity made the conference a successful and memorable one for all who attended.

The next international congress of the IACCP will be held in Reims, France, 15-19 July, 2014, in conjunction with the 31st International Congress of Applied Psychology (to be held 8-13 July, in Paris).

Outcomes of IUPsyS General Assembly 2012

Janel Gauthier, Ph.D. and John Berry, Ph.D.

The 2012 General Assembly of the International Union of Psychological Science (IUPsyS) was held in conjunction with the International Congress of Psychology (ICP) on July 23 and July 25 in Cape Town, South Africa. IUPsyS aims to promote "the development, representation and advancement of psychology as a basic and applied science nationally, regionally, and internationally" (Article 5, IUPsyS Statutes). It represents psychology in its full breadth as a science and as a profession" (www.iupsys.net). Representatives of its member nations meet biannually in conjunction with the International Congress of Psychology (its principal quadrennial meeting) and the International Congress of Applied Psychology (the quadrennial meeting of the International Association of Applied Psychology).

Prof. John Berry and Prof. Janel Gauthier attended as delegates on behalf of Canada. Canadians Prof. Pierre Ritchie, IUPsyS Secretary-General, and Prof. Michel Sabourin, IUPsyS Treasurer also attended as non-voting members of the General Assembly in their appointed roles as members of the IUPsyS Executive Committee (EC).

As this marked the end of an IUPsyS quadrennium, the important business included the changing of the Executive Committee. Of special note to Canada, this meeting marked the end of Prof. Ritchie's service as Secretary-General of IUPsyS, a position he has held since 1996. Dr. Ann Watts (South Africa) is the new Secretary-General.

Many CPA members will recall meeting Dr. Saths Cooper (South Africa) during his visit to the CPA Convention in Toronto in 2011. Dr. Cooper was elected President of IUPsyS at this General Assembly. Prof. Michel Sabourin (Canada) was re-appointed Treasurer (2012-2014) and Prof. Jean-Pierre Blondin (Canada) was appointed Treasurer-Designate for the same period, with the expectation that he will become Treasurer at the next General Assembly meeting. Other elections and appointments are listed on the IUPsyS web site.

The Union consists of National Member organizations, not more than one National Member coming from any one country. Recent years have seen many developing nations join IUPsyS. As of this General Assembly, IUPsyS National Members now include Botswana, Brazil, Cyprus, Grenada, Lebanon, Malaysia, Mozambique, Sri Lanka, and Trinidad and Tobago.

The work of the Union is guided by its strategic plan. The plan adopted by the General Assembly sets five priorities: capacity building; international representation; service to national members; service to the discipline (i.e., development of the discipline's common core); and, communications and dissemination. Among the ongoing capacity-building activities are the Advanced Research Training Seminars (ARTS), which are aimed at early career scientists from low-income countries. CPA provides financial support for ARTS. In the area of service to the discipline, among other activities, IUPsyS has established four awards that will be granted at each ICP, starting in 2012. The first recipient of the IUPsyS Young Investigator Award (Basic Science) was Dr. William Cunningham of the University of Toronto, for research on motivation and affect regulation.

The Statutes of the Union establish its operating principles and practices and are reviewed at each General Assembly. An important change made in 2012 concerns Article 3, in which IUPsyS asserts its adherence to the principle of Universality of Science articulated by the International Council for Science (ICSU). This article of the IUPsyS statutes was changed to maintain its consistency with the ICSU principle. The changes clarified that the Universality of Science embodies free and responsible practice of science and equitable opportunities for access to science and its benefits.

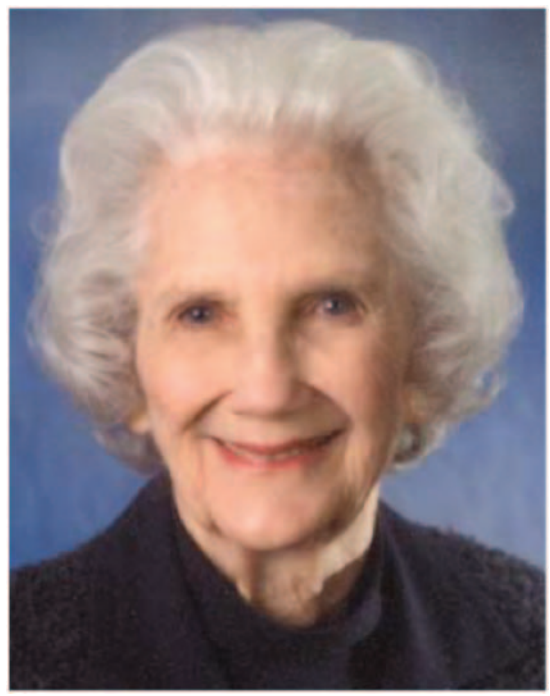
The next IUPsyS General Assembly will be held in Paris in 2014 in conjunction with the International Congress of Applied Psychology (July 8-13, 2014). One new Canadian delegate will be appointed before that meeting, taking the place of Prof. Gauthier when his term will end.

CPA and Canadian Psychology say good-bye to a remarkable Canadian psychologist

Dr. Bea Wickett 1917 – 2012

K.R. Cohen, Ph.D., CEO, CPA

It is with great sadness that I report on the passing of Dr. Beatrice Enid Wickett-Nesbitt, C.M., B.A., M.A., D.Ed., LLD. Bea died on September 10, 2012, at the age of 95, in Calgary, Alberta. Her passing marks the close of a truly remarkable personal and professional life. She was predeceased by her first husband, John Wickett in 1976 and by her second husband, Herbert Nesbitt in 2002. She was the mother of three children, five grandchildren and nine great grandchildern.



Raised in Alberta, Bea completed her B.A. Honours in psychology at Acadia University and went on to complete her master's degree at Brown University as well as further graduate work at McGill University. Honorary degrees followed — an Honorary Doctorate of Education from Acadia University in 1980 and a Doctor of Laws, Honoris Causa, from Carleton University in 1995.

Bea's career began more auspiciously than most psychologists can even imagine. She worked with Dr. Wilder Penfield at the Montreal Neurological Institute during the war years at the time that he began mapping the sensory and motor cortex. Bea's career took two more significant turns. To quote her obituary, "from 1962 until her retirement in 1983, she was Chief Psychologist at the Ottawa Board of Education. There she established programmes for special needs and disadvantaged children; one of her proudest accomplishments was the "Step-by-Step" programme where volunteers were matched with emotionally disturbed children, a programme that spread both in Canada and abroad. She also set up a unique in-house staff counseling programme, the first of its kind in Canada. After retirement from the Board, she helped form the Ottawa-Carleton Regional Palliative Care Association and was resident psychologist with the palliative care unit at Élisabeth Bruyère Health Centre."[i]

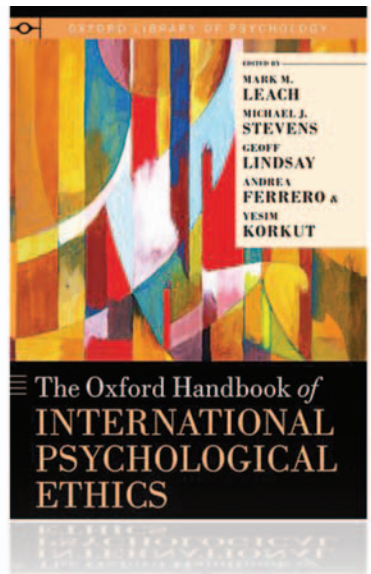
Bea's many professional contributions were appreciated by so many. This appreciation included the Order of Canada, the Lieutenant Governor of Alberta Diamond Jubilee, the Award of Merit from the Ontario Psychological Association, the Ontario Public School Teachers' Federation Meritorious Award, the Canadian Rehabilitation Council's "Most Innovative Program of the Year" Award and the Margaret Griffiths Award from the Council on Aging. Bea volunteered so much of herself to CPA and to CPA's Foundation as well and received CPA's Award for Distinguished Lifetime Service to the CPA. All this in addition to the tireless and expert contributions she made to many charitable agencies and advisory committees over the course of her life.

I felt very fortunate to have known Bea well since she spent much of her professional life in Ottawa. It is difficult to say whether she impressed me most for her contributions to the practice of school and child psychology, for her generous and expert participation in organized psychology or for the fact that she was, simply put, the kindest and most caring human being. She never missed an opportunity to say or send a kind word or make a donation. Indeed for many years, the CPA Foundation's silent auction was made possible by her benefaction. Bea, through word and deed, really showed us that making a difference is possible – a difference as a psychologist, as a colleague and as a friend. Thank you Dr. Wickett. Rest in peace.

[i] http://www.legacy.com/obituaries/ottawacitizen/obituary.aspx?pid=159870420#fbLoggedOut

Psychologists Go International on Ethics

Jean L. Pettifor, Ph.D.
Member, CPA Committee on Ethics



The most recent book to address the continuing evolution of professional ethics from its early development to today's search for international relevance and universality is *The Oxford Handbook of International Psychological Ethics (2012),* published by Oxford University Press. To quote Michael Knowles, past-president of the International Association of Applied Psychology, "Never before has there been such a comprehensive coverage of the field, ranging from the origin and evolution of ethical thought to present day challenges presented by factors ranging from the internet to globalization, while at the same time fully discussing cultural variations between and within the major regions of the world."

The book has contributions from psychologists around the world and is divided into five parts, namely, 1) Overview of International Psychological Ethics, 2) Current and Emerging International Ethical and Professional Development Issues, 3) Psychological Ethics in Wider Contexts, 4) Psychological Ethics by Region: Convergence and Divergence, and 5) Economic, Political and Social Influences on Psychological Ethics and Ethics Code Development.

Canadian psychologists contributed to four of the 34 chapters. Carole Sinclair authors the opening chapter on *Ethical Principles, Values and Codes for Psychologists: An Historical Journey.* The journey begins in ancient times and pauses with today's perspectives. By examining laws, oaths, prayers and formal codification related to professional practice over the centuries and around the world, considerable similarity in ethical principles and values are found, although there are variations in how they are expressed.

Jean Pettifor, with Andrea Ferrero of Argentina, authors Chapter 3 on *Ethical Dilemmas, Cultural Differences and the Globalization of Psychology*. Focusing primarily on life-like ethical dilemmas as a practical way of addressing issues in coping with the drive toward globalization, they demonstrate that codification undertaken in one culture may not be responsive to beliefs in another culture, and emphasize the importance of placing the well-being of the client as the first priority in making ethical choices in such situations.

Janel Gauthier and Jean Pettifor author Chapter 9, *A Tale of Two Universal Declarations: Ethics and Human Rights*. They clarify the differences in purpose and function between the *United Nations Universal Declaration of Human Rights* (1948) and the *Universal Declaration of Ethical Principles for Psychologists* (2008), while at the same time recognize the common base of humanitarian values and the role of such values in meeting today's global challenges.

Thomas Hadjistavropoulos, with Gerald Koocher of the USA, authors *North America: Canada and the United States* under Part Four on Psychological Ethics by Region: Convergence and Divergence. They identify the major similarities and differences in Canada and the United States in the legal status of the discipline, the national professional associations, ethics committees, ethics training, and in research on ethics, as well as discuss the ethical challenges for both countries resulting from technological advances.

This *Oxford Handbook* has been created against a backdrop of societal changes toward globalization and a steadily increasing stream of ethics presentations at international psychology congresses over the past 15 to 20 years. Thanks goes to the editors for their insight in producing such an exciting, stimulating and thought-provoking book.

Call for Nominations for the Canadian National Committee for the International Union of Psychological Science (CNC/IUPsyS)

The CNC/IUPsyS is a CPA committee that enacts Canada's participation in the International Union of Psychological Science under a partnership agreement with the National Research Council of Canada. To ensure that the membership is representative of the diversity of psychological science, at-large members of the committee hold positions designated for psychologists whose research falls into one of three broad research domains: health science, neuro-bio-behavioural science, or social science.

Nominations are required from CPA Members and Fellows for three members-at-large, one in each of the three domains (**health science, neuro-bio-behavioural science, or social science**), for 4-year terms beginning at the CPA Convention in 2013 (i.e., 2013-2017).

In addition, nominations are open for the position of **Chair of the CNC/IUPsyS**, for a 4-year term from 2013-2017.

Any CPA Member or Fellow whose primary activities are in research and teaching may be nominated. Given the nature of the Committee, candidates who are members of an international association or who have attended at least one international congress will be given preference.

Each nomination shall consist of:

- a letter from the nominator that states the position for which the candidate is being nominated, expresses support for the candidate, and contains a statement to the effect that the nominator has ascertained the candidate's willingness to stand for nomination;
- a current curriculum vitae of the candidate (including educational background, present and former positions, research and professional activities, organization membership and involvement, and international congress participation); and
- supporting statements from two CPA Members/Fellows.

The deadline to submit nominations shall be JANUARY 31, 2013. Nominations and supporting documents should be sent by e-mail to the Secretary of the CNC/IUPsyS at **cnc-iupsys@cpa.ca.**

Goethe Award for Psychoanalytic and Psychodynamic Scholarship (for the 2011 publication year)

The Selection Committee of the CPA Section on Psychoanalytic and Psychodynamic Psychology is pleased to announce this year's Goethe Award Finalists and Winner.

In 1930, Freud was awarded the 'Goethe Prize' for his literary and recognized scientific achievements. The Goethe Award for Psychoanalytic Scholarship is given by the Canadian Psychological Association's Section on Psychoanalytic and Psychodynamic Psychology for the best psychoanalytic and/or psychodynamic book written each year. This award considers any disciplinary or interdisciplinary subject matter in theoretical, clinical, or applied psychodynamic/analytic psychology and is judged on the basis of providing an outstanding contribution to the field.

Congratulations to all Finalists and this year's winner!

This year's **2011 Goethe Award Winner** is:

Nancy McWilliams' ***Psychoanalytic Diagnosis, Second Edition: Understanding Personality Structure in the Clinical Process,*** **by** Guilford Press**, New York** (ISBN-13: 978-1609184940)

The Committee also named two titles as **Finalists for the Goethe Award (2011)**. This year's Finalists are:

Paul Wachtel's *Therapeutic Communication, Second Edition: Knowing what to say and when,* published by Guilford Press, New York (ISBN: 1609181719)

And,

Morris Eagle's from classical to contemporary psychoanalysis: a critique and integration, by Routledge, New York (ISBN: 0415871611)

Correspondence regarding this announcement may be directed to Dr. Heather MacIntosh, Co-ordinator, Goethe Award, Section on Psychoanalytic and Psychodynamic Psychology, heather.macintosh@mcgill.ca

Guilford has indicated that they would be pleased to offer members of the Canadian Psychological Association a 20% discount on Psychoanalytic Diagnosis, Second Edition. To order the book and receive the discount, visit http://www.guilford.com/p/mcwilliams and enter code 3C at checkout. The offer is valid through December 2015.

An Invitation to Join a New CPA Section

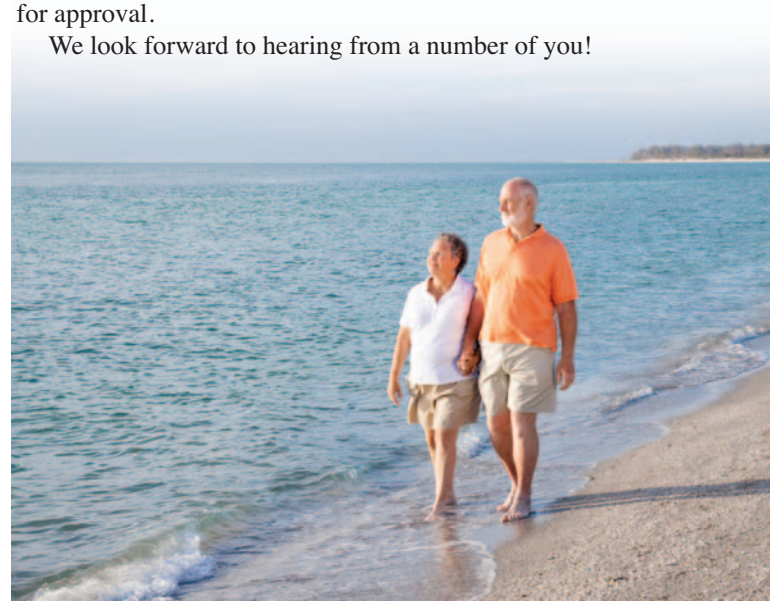
Retirement has been called "the 3rd Act" of life, or alternatively, equated to Erickson's Adolescent Stage of Development because the task of retirement, similar to adolescence, is to find a new identity. Retirement is something we will all, hopefully if we are blessed with good health, face at some point of life. How we handle it will depend to a large extent on how closely we've identified with our profession, how well we've preserved our personal and family relationships, and how we reach out to the new opportunities open to us and are able to let go of the old responsibilities.

Psychologists find retirement of interest from both a personal and professional perspective. Some of us have reached that stage of life and wonder, "So, what does a retired psychologist DO?" Some work with retirees in their practices or within their own families and attempt assist with the transition to the 3rd Act. While others embrace new challenges through stimulating volunteer work

We are hoping to establish a **Section for Psychologists and Retirement** within CPA, to meet the needs of both retired psychologists and those interested in retirement. The new Section will provide a forum for psychologists who are currently retired from their professional employment in the field of psychology and/or those who are interested in the area of retirement as a life stage to discuss the impact of retirement on post-work quality of life and the opportunities it affords those who are open to change. The organizers envision creating a network of social support and information for retired psychologists, reviewing and possibly conducting research on retirement, assisting CPA in preparing position papers when needed, and organizing a Convention program of interest to members.

To form a new Section, we need your support. If you are interested in joining the Section for Psychologists and Retirement, please respond to Juanita Mureika (Juanita.mkm@gmail.com), who will be collecting names to submit, along with the mission statement, to the CPA Board for approval.

We look forward to hearing from a number of you!



Section on Women & Psychology Annual Student Awards

The Section on Women and Psychology (SWAP) is pleased to announce that **Jenna MacKay** is the 2012 winner of the SWAP Student Paper Award. The winning paper, entitled **"Naming Violence Against Women in Ontario"**, was presented at the 2012 CPA annual convention. Ms. MacKay is a graduate student in the Social Psychology program in the Department of Psychology at Carlton University, supervised by Dr. Connie Kristiansen, who co-authored the paper. The $500 award was presented to Ms. MacKay at the SWAP business meeting during the convention.

SWAP also awarded five $250 travel bursaries to students presenting papers or posters particularly relevant to women and/or feminism at the CPA convention or SWAP-sponsored pre-conference Institute. Travel bursaries were awarded to Sobia Ali-Faisal (University of Windsor), Kimberley Cullen (York University), Sandra Dixon (University of Calgary), Kerry Erickson (University of British Columbia), and Natalie Michel (University of Guelph).

E.B. Brownlie, Ph.D., Student Awards Coordinator, Section for Women and Psychology.

Inaugural Section Newsletter Award Winner!

Congratulations to the first Section Newsletter Award Winner: Clinical Section.

To view the Clinical Section's 2011 winning Newsletter: http://www.cpa.ca/aboutcpa/cpasections/clinicalpsychology/clinicalsectionpublications/

We Welcome Submissions for the 2nd Section Newsletter Award

CPA recognizes the efforts that sections put into creating and maintaining their newsletters. The newsletters serve as an important communication tool to help keep members informed and involved in the section and in CPA. In recognition of this effort, we would like to give an award for the best newsletter distributed by a CPA section. The winner will receive a certificate and a monetary award of $250 and will be highlighted in the fall issue of Psynopsis and on the news section of the web site.

To be considered for the award, sections must send an electronic copy of their best newsletter issue **from 2012** to CPA (publicrelations@cpa.ca) by February 1, 2013. The membership committee will review all the entries received and select a winner. The following criteria will be used to determine the winner:

- Informational content
- knowledge translation
- engagement/interest
- design/creativity
- contributions from multiple individuals
- student content

Environmental Psychology 2012 Robert Sommer Award for Best Student Paper

At the Halifax convention, the Section on Environmental Psychology awarded the second annual Robert Sommer Award for Best Student Paper in Environmental Psychology to PhD student Christine Kormos of the University of Victoria for a paper co-authored by her advisor Prof. Robert Gifford, titled "The Validity of Self-Report Measures of Proenvironmental Behavior: A Meta-Analytic Review" Here is a short summary of the paper:

Research aimed at understanding psychological factors that contribute to proenvironmental behavior relies heavily on self-report measures, but evidence of their validity is mixed. This meta-analysis quantified the association between self-reported and objective measures of proenvironmental behavior in the literature, and evaluated the potential influence of socio-demographic and methodological moderators. We searched for relevant articles in PsycINFO, ProQuest, relevant reference lists, and a listserve. Among 6260 individuals or households, across 15 studies, a moderately large effect size (r = .46) was found in that self-reported measures were positively correlated with objective measures, 95% CI = 0.28 – 0.60, Z-value = 4.66, p < .001. Significant heterogeneity was detected: self-report validity increased along with the proportion of males, and validity also varied across countries. No evidence of systematic bias (under-reporting or over-reporting of objective measures) was detected. The influence of publication bias was minimal. Implications for theory development and behavioral interventions are discussed.

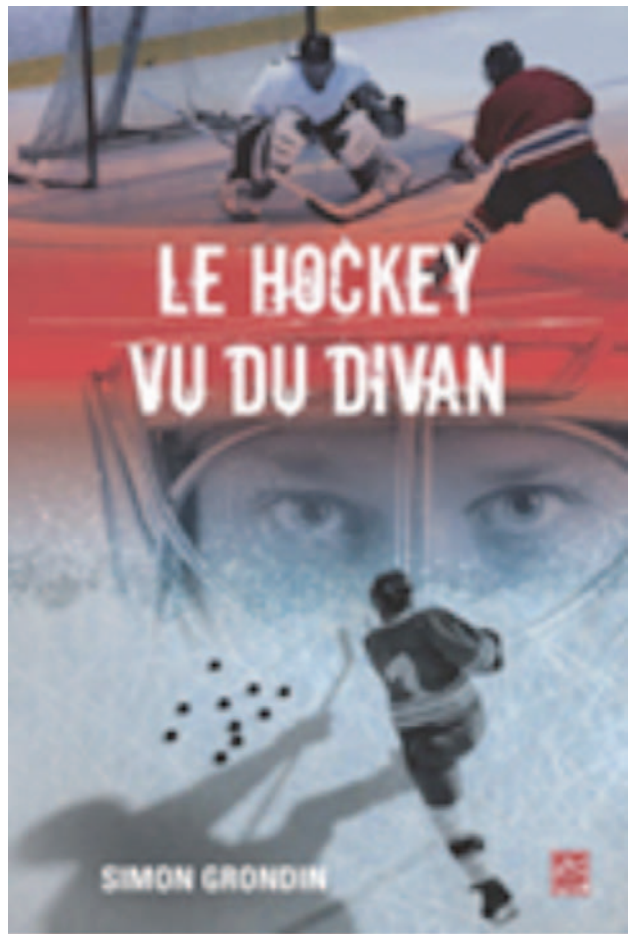
The award commemorates the role of psychologist Robert Sommer in the creation of the field with his research at the Saskatchewan Hospital in Weyburn in the 1950s, which was described in the landmark book *Personal Space: The Behavioral Basis of Design*. Robert Sommer's amazingly prolific body of work covers many topics, but the common theme has always involved staying close to the real world and trying to make a difference in what he sees around him.

The award is judged by an independent panel of three reviewers based on extended abstracts of original research in environmental psychology for which the first author is an undergraduate or graduate student. The work need not have been presented at a CPA convention, and the student need not be a member of the Section on Environmental Psychology. This year's review panel included Mark Sandilands, John Tivendell, and John Zelenski. Recipients receive a certificate and a cheque for $300.

Students, watch for the call for the 2013 Robert Sommer Award competition, with dates and submission information to be announced in December.

Le hockey vu du divan (Hockey seen from the Couch)

Once in a while, professors and researchers in Psychology take a risk and publish work that falls a little outside of their usual research activity. It is in this context that Simon Grondin has authored a new book entitled "**Le hockey vu du divan"** (Hockey seen from the couch), just released by the *Presses de l'Université Laval* (PUL) This book focuses on ice hockey, mainly played in National Hockey League (NHL), and is intended for a wide audience. The book will be of most interest to hockey fans because of the many references to players, teams and historical events in the NHL. However, the author uses general concepts in Psychology to help the reader understand hockey and its context and, for this reason, the book is of interest to psychologists as well.



Both serious and entertaining, the book is considerably different from other books written on ice hockey. The book explores many facets and issues in hockey and includes synopses of concerns and debates that have captivated hockey fans. These include issues of violence, superstition and the personal development of players. The book's tone is sometimes personal and sometimes more educative about issues and concepts discussed.

Warm-up (Chapter 1) to Overtime (Chapter 12) covers three periods each with three or four corresponding chapters. The first period tries to show that, given the changes in rules governing the game over decades, there is no "real hockey". If refereed well, hockey as we know it could be as intense but much less violent. In the second period, the author addresses the roles, responsibilities and remuneration of NHL players – how remuneration is justified and what teams contribute to their communities. In the third period, a variety of topics are discussed, often using psychological principles to explain, at least partially, some intriguing hockey phenomena. In the third period, the reader will find responses to questions such as: Why do players sometimes have mania? Is it true that a young boy has better chances of reaching the NHL if he is born in the early months of the year? Do all right-handers shoot from the left?

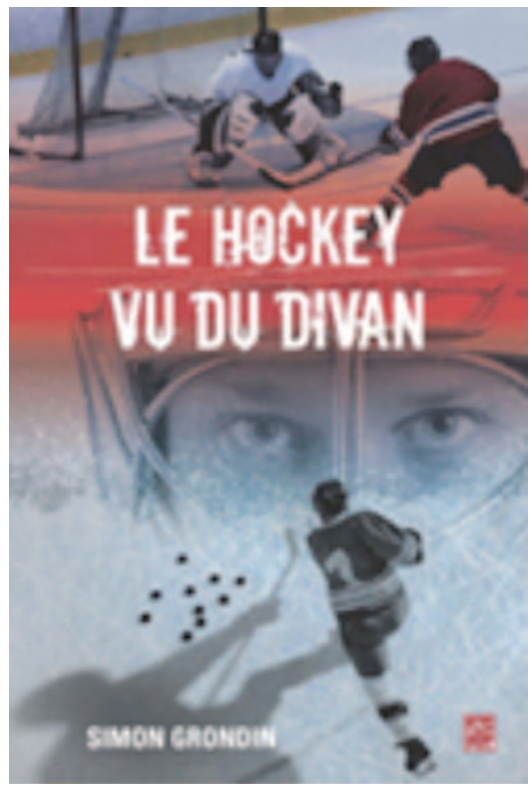
Ice hockey in Canada and Québec is at the core of our collective identity, be it Canadian or Québécoise. This book explains and reminds us why hockey is so exciting. It brings to life the miseries and splendor of this simple game played on a grand scale. If this book is ever published in English, the author might be tempted to call it "Couch's corner!"

You can access a detailed oral description (in French) of the book on youtube (youtube.com/watch?v=Th4gWaS0P4k) or may access the book via the Web site of PUL (http://www.pulaval.com/catalogue/hockey-divan-9761.html).

Simon Grondin is a professor at École de psychologie of Université Laval, and is a Fellow of the CPA. He is the former Editor of the Canadian Journal of Experimental Psychology (2006-2009) and a former Associate Editor of Canadian Psychology (2003-2006).

Le hockey vu du divan

Il arrive que des professeurs et chercheurs en psychologie publient un livre qui est un peu en marge de leurs principales activités de recherche. C'est ainsi que Simon Grondin vient de faire paraître aux Presses de l'Université Laval un ouvrage intitulé « Le hockey vu du divan ». Ce livre porte sur le hockey sur glace, principalement sur celui de la Ligue nationale de hockey (LNH) et est destiné à un vaste public. Bien qu'il soit susceptible d'intéresser en premier lieu les amateurs de hockey en raison des nombreuses références à certains joueurs, à certaines équipes et à certains événements historiques entourant la LNH, le livre a un intérêt particulier pour les psychologues car il permet de comprendre certains aspects entourant le monde du hockey à l'aide de notions générales de psychologie.



À la fois sérieux et divertissant, l'ouvrage se démarque considérablement des autres livres écrits sur le hockey. Bien qu'il s'agisse d'un essai, les thèmes sont diversifiés et l'ensemble du livre ne tourne pas autour d'une seule idée principale. L'ouvrage offre des synthèses de certains débats liés à des thèmes pour la plupart très populaires auprès des amateurs de hockey et propose d'approfondir le regard que l'on peut poser sur des sujets comme la violence, la superstition ou le développement personnel. Le ton adopté est tantôt personnel, tantôt marqué par la distance nécessaire aux explications.

Entre un échauffement (Chapitre 1) où il est question de l'histoire de la LNH à travers sa manière de déterminer un gagnant lors d'un match ou lors des séries éliminatoires, et une prolongation (Chapitre12) où il est beaucoup question des principaux records dans l'histoire de la LNH, l'ouvrage comporte trois périodes comprenant chacune trois ou quatre chapitres. La première période tente de montrer que, compte tenu de l'évolution des règlements, l'idée de « vrai hockey » n'a pas de sens et que, arbitré correctement, le hockey pourrait être beaucoup moins violent sans que l'intensité du jeu en soit affectée. En fait, le hockey est sain mais l'esprit qui s'y est développé en Amérique du Nord l'est moins. Dans la deuxième période, on essaye de voir ce qui pèse sur les épaules des joueurs qui permet de justifier les salaires élevés et il est aussi question de la valeur d'une équipe de hockey pour une communauté donnée. Lors de la troisième période, différents thèmes relatifs au hockey sont abordés de manière à montrer que sous certains phénomènes intrigants se trouve une mécanique qui permet de les expliquer, au moins partiellement. On essaye de répondre à des questions comme les suivantes. Pourquoi les joueurs ont-ils plein de manies ? Est-ce qu'un enfant a plus de chances de jouer dans la LNH s'il est né dans les premiers mois de l'année plutôt que dans les derniers ? Est-ce que tous les droitiers lancent de la gauche ?

L'omniprésence du hockey au Canada et au Québec le place au cœur de la formation de l'identité collective, qu'elle soit canadienne ou québécoise. Au terme de la lecture de ce livre, on comprend mieux pourquoi le hockey est si passionnant. Sous ce qui semble n'être en apparence qu'un simple jeu se trouvent en réalité toutes les petites misères de la vraie vie et aussi toute sa splendeur. Si ce livre devait un jour paraître en anglais, on pourrait toujours l'appeler « Couch's corner » !

Le lecteur intéressé par ce livre pourra trouver une description plus détaillée sur youtube (youtube.com/watch?v=Th4gWaS0P4k) ou y avoir accès en se rendant sur le site des PUL (http://www.pulaval.com/catalogue/hockey-divan-9761.html).

Simon Grondin est professeur à l'École de psychologie de l'Université Laval et Fellow de la SCP. Il a été Rédacteur en chef de la Revue canadienne de psychologie expérimentale (2006-2009) et Rédacteur adjoint de Psychologie canadienne (2003-2006).

Second Call for Nominations for President-Elect and Five Directors on the CPA Board of Directors for 2013

Nominations are required for President-elect and five Directors who will assume office at the 2013 Annual General Meeting. Three Director-at-large positions are to be nominated by all members as defined in By-Law IX (1) B*. One position is reserved for **an experimental psychologist who is conducting basic research**. In addition, one seat is **reserved for a Masters level psychologist**, as provided in By-Law IX (1) B (ii).

One Director for Designated Scientist-Practitioner and one Scientist are to be nominated through Sections as defined in By-Laws IX.A.

The President-elect is nominated by all members as defined in By-Law IX.3. Please note that nominations for at-large Directors and President-elect require the support of **five Members/Fellows** as defined in By-Law IX.3(i).

INSTRUCTIONS FOR NOMINATIONS FOR PRESIDENT-ELECT AND THREE DIRECTORS-AT-LARGE

Members and Fellows of the Canadian Psychological Association are invited to nominate for the President-elect and three Director-at-large positions on the Board of Directors. One position is reserved for **an experimental psychologist who is conducting basic research and** as prescribed in By-Law IX (1) B (ii)* **the Board of Directors has reserved one seat for a Masters level Psychologist**.

Each nomination must include a curriculum vitae for the candidate, including educational background, present and former positions, and research and/or professional activities. **It must be accompanied by a letter from the nominator and four letters of support** that states the position for which the candidate is being nominated, expresses support for the candidate, and contains a statement to the effect that the nominator has ascertained the candidate's willingness to stand for nomination.

The names and supporting materials of nominees must be received by **November 9, 2012** at CPA Head Office and should be sent preferably by email to:

cpa@cpa.ca
Dr. David Dozois
Chair, Nominating Committee
Canadian Psychological Association
141, Laurier Ave. West, Suite 702
Ottawa, Ontario K1P 5J3

INSTRUCTIONS FOR TWO SECTION-NOMINATED DESIGNATED DIRECTORS -SCIENTIST-PRACTITIONER AND SCIENTIST POSITIONS

Designated Directors who are nominated by the Sections represent the three categories of Scientist, Scientist-Practitioner and Practitioner. For the 2013 elections, nominations are required for one Scientist-Practitioner seat and one Scientist seat.

As presented in By-Law IX, any CPA Member or Fellow who is a member of a section(s) may submit a nomination(s) to any section(s) of which they are a member. The sections shall establish their own procedures for the consideration of nominations received from their members for designated board seats.

All sections are invited to submit nominations for the section-nominated designated positions of **Scientist-Practitioner and Scientist**.

Scientist-Practitioners can be defined as one of the following: (a) A Scientist whose primary activities are in research and teaching and who focuses mainly on the application of psychological principles to specific applied problems. The main concern of this scientist is to produce research findings that are readily applicable to real world problems. This person differs from the traditional Scientist in the direct concern for the applicability of research findings to contemporary, real world problems.

OR

(b) A Practitioner who uses research methodology in solving real world problems. This type of Practitioner is not simply concerned with solving the particular problem at hand, but attempts to conduct research which will be useful to others in the field who have similar problems. This person differs from the traditional Practitioner in the use of research methodology in her or his work and in the concern for generalizability of findings produced through the research performed to solve specific problems to other situations.

Scientists are persons who indicate that their major professional activity involves research and teaching, and whose CVs are judged by the Nominating Section to meet these criteria.

The submission of each nomination will include the written consent of the nominee, the curriculum vitae of the nominee, and a supporting letter from the nominator.

The name(s) of section nominee(s) for the designated Directors Scientist-Practitioner and Scientist positions must be received at CPA Head Office by **November 9, 2012** and should be sent preferably by email to:

cpa@cpa.ca
Ms. Dawn Hanson
Chair, CPA Committee on Sections
Canadian Psychological Association
141 Laurier Ave. West, Suite 702
Ottawa, Ontario K1P 5J3

Continued on next page

Second Call for Nominations for Election to the Status of Fellow of the Canadian Psychological Association 2013

The Committee on Fellows invites you to recognize the distinguished contributions of your colleagues by nominating them for consideration by the Committee. Nominees must be Members in good standing of the Association. Should the nominee not be selected as a Fellow the year submitted, he or she will automatically be reconsidered in each of the next two years.

Any Member, except current members of the CPA Board of Directors, can be nominated for Fellow status. Members may not nominate themselves and current CPA Board members may not nominate. As noted in the By-Laws, there are three ways to achieve Fellow status: (1) distinguished contributions to the advancement of the science of psychology; (2) distinguished contributions to the advancement of the profession of psychology; and (3) exceptional service to national or provincial associations of psychologists.

Nominations must be made as follows:

Nominations must include a current curriculum vitae for the nominee and **at least three endorsing letters** written in the last calendar year by current Fellows or Members. Preferably, the nominators should be drawn from three different institutions, with no more than one coming from the nominee's home institution.

The letters of nomination should be specific about the ways in which the nominee's research or practice has contributed to the advancement of the science or profession of psychology or as to ways the person's service to national or provincial associations of psychologists have been exceptional. In the case of nominations based upon accomplishments other than published theory or research, the specific innovative contributions and their impact on psychology should be described.

The letters of nomination should point out evidence of the quality of journals in which the nominee has published, awards received, etc. In the case of nominations based upon exceptional service to national or provincial associations of psychologists, the letters of nomination should point the nature of the associations (e.g., nature of the associations, number of members, services they provide).

Normally, the nominee should have completed his or her post-secondary training 10 years prior to being nominated for Fellow status. Someone with less than 10 years experience following graduation, but more than 5 years of experience, could be elected Fellow if his or her contributions or services have been found by the Committee to be truly exceptional.

Nominations must be submitted preferably by email (in PDF format) **by NOVEMBER 30**, and must be accompanied by the nominee's curriculum vitae/resume, together with s**upporting statements by at least three nominators**, to:

cpa@cpa.ca
Dr. David Dozois
Chair, CPA Committee on Fellows and Awards
Canadian Psychological Association
141, Laurier Ave. West, Suite 702, Ottawa, Ontario K1P 5J3
The list of CPA Fellows is available on the CPA Web Site at
http://www.cpa.ca/aboutcpa/cpaawards/fellows/

PRESENT BOARD REPRESENTATION

So that you may be aware of the present balance of the Board, its current voting membership is as follows:

President: Jennifer Frain, New Directions for Children, Youth, Adults & Family, Winnipeg, MB

Past-President: David Dozois, University of Western Ontario, London, ON, Clinical

President-elect: Wolfgang Linden, University of British Columbia, Vancouver, BC, Clinical

Directors retiring 2013

Scientist: John Meyer, University of Western Ontario, Industrial/Organizational

Scientist-Practitioner: Mary-Pat McAndrews, Toronto Western Hospital, ON, Neuropsychology

At-large reserved for a Masters level member: Dawn Hanson, Winnipeg, MB, Private Practice

At-large: Sylvie Bourgeois, RCMP, Ottawa, Ontario, Health Psychology

Experimental Psychologist Conducting Basic Research: Aimée Surprenant, Memorial University, NL

Director retiring 2014

Practitioner: Dorothy Cotton, Kingston, ON, Neuropsychology, Criminal Justice System

Director retiring 2015

At-large reserved for a Francophone: Marie-Hélène Pelletier, Private Practice, Vancouver, BC

***By-law IX - Nominations - is available on cpa web site:**
http://cpa.ca/aboutcpa/cpabylaws/

Rappel de mises en candidature au conseil d'administration de la SCP pour les postes de président désigné et de cinq postes de directeurs pour 2013

Des mises en candidature sont requises pour les postes de président désigné et de cinq directeurs qui assumeront leurs fonctions lors de l'assemblée générale annuelle de 2013. Trois directeurs non désignés doivent être nommés par tous les membres tel que stipulé dans le règlement IX (1) B*. Un poste est réservé à **un(e) psychologue engagé dans la recherche fondamentale**. De plus, tel que stipulé dans le règlement IX (1) B (ii), le conseil d'administration a réservé un siège de directeur non désigné à **un(e) psychologue détenant une Maîtrise.**

Deux postes de directeurs désignés scientifique praticien et scientifique nommés par les sections sont aussi requis comme le stipule le règlement IX.A.

Conformément au règlement IX.3, le président désigné et les directeurs non désignés sont nommés par tous les membres et les mises en candidature **doivent être appuyées par cinq membres ou fellows.**

DIRECTIVES POUR LES MISES EN CANDIDATURE POUR LES POSTES DE PRÉSIDENT DÉSIGNÉ ET DE TROIS DIRECTEURS NON DÉSIGNÉS

Les membres et fellows de la Société canadienne de psychologie sont invités à faire des mises en candidature pour les postes de président désigné et de trois directeurs non désignés, dont un poste est réservé à **un(e) psychologue engagé dans la recherche fondamentale**. De plus, tel que stipulé dans le règlement IX (1) B (ii)*, **le conseil d'administration a réservé un siège de directeur non désigné à un(e) psychologue détenant une Maîtrise.**

Chaque candidature devra être accompagnée du curriculum vitae du candidat et devra inclure ses antécédents en matière de formation, le(s) poste(s) qu'il occupe présentement et qu'il occupait auparavant ainsi qu'un résumé de ses activités professionnelles ou dans le domaine de la recherche. **La mise en candidature devra être également accompagnée d'une lettre du présentateur et quatre lettres d'appui** mentionnant le poste pour lequel ce candidat est nommé et, finalement, la mise en candidature devra renfermer une déclaration à l'effet que la personne nommée accepte de se porter candidate à l'élection.

Assurez-vous de faire parvenir vos mises en candidature pour les postes de président désigné et de directeurs non désignés accompagnées des pièces nécessaires pour appuyer ces candidatures au plus tard le **9 novembre 2012**, préférablement par courriel, à l'adresse suivante :

cpa@cpa.ca
Dr David Dozois
Président du Comité des mises en candidature
Société canadienne de psychologie
141 avenue Laurier ouest, bureau 702
Ottawa, Ontario K1P 5J3

DIRECTIVES POUR LES MISES EN CANDIDATURE POUR LES POSTES DE DIRECTEURS DÉSIGNÉS SCIENTIFIQUE-PRATICIEN ET SCIENTIFIQUE NOMMÉS PAR LES SECTIONS

Les directeurs désignés nommés par les sections représentent les trois catégories de membres de la SCP : scientifique, scientifique praticien et praticien. Pour les élections de 2013, des candidatures pour un poste de scientifique-praticien et un poste de scientifique sont requises.

Tel que stipulé dans le règlement IX, tout membre ou fellow de la SCP qui est également membre d'une ou de plusieurs sections peut présenter une mise en candidature à la section (ou sections) dont il est membre. Les sections ont la responsabilité de déterminer leurs propres procédures pour examiner les mises en candidature qu'elles auront reçues de leurs membres pour les postes désignés du conseil.

Toutes les Sections sont invitées à faire des mises en candidature pour les postes vacants de **scientifique-praticien et de scientifique.**

Les **scientifiques-praticiens** peuvent être définis comme étant soit, a) un scientifique dont les activités principales se situent dans le domaine de la recherche et de l'enseignement et qui se concentre sur l'application des principes psychologiques à des problèmes appliqués spécifiques. Ses principales activités professionnelles sont de faire des découvertes dans le domaine de la recherche pouvant facilement s'appliquer aux problèmes du monde réel. Cette personne se distingue du scientifique traditionnel par sa préoccupation directe pour l'aspect applicable des découvertes découlant de sa recherche aux problèmes contemporains du monde réel.

OU

b) un praticien qui utilise une méthodologie de recherche afin de résoudre les problèmes du monde réel. Ce genre de praticien ne se contente pas de résoudre un problème particulier mais il s'occupe de faire de la recherche qui sera utile à d'autres professionnels dans le même domaine et ayant des problèmes semblables. Cette personne se distingue du praticien traditionnel dans le sens qu'il utilise la méthodologie de la recherche dans son travail et dans son souci de généraliser les découvertes émanant de la recherche afin de résoudre des problèmes spécifiques et de les appliquer à d'autres situations.

Les **scientifiques** sont des personnes qui ont indiqué la recherche et l'enseignement comme principales activités professionnelles et dont le curriculum vitae est jugé conforme à ces critères par la Section faisant la mise en candidature. La présentation de chaque candidature comprendra le consentement du candidat ainsi que son curriculum vitae et une lettre du présentateur du candidat.

Chacune des sections doit faire parvenir le nom de leurs candidats aux postes de directeur désigné scientifique et praticien au responsable du Comité sur les sections **avant le 9 novembre 2012** préférablement par courriel à l'adresse suivante :

cpa@cpa.ca
Mme Dawn Hanson
Présidente du Comité sur les Sections
Société canadienne de psychologie
141, avenue Laurier ouest, bureau 702
Ottawa, Ontario K1P 5H3

Rappel de mises en candidature pour le titre de fellow de la Société Canadienne de Psychologie pour 2013

Le Comité des fellows vous invite à souligner la contribution de vos collègues en lui présentant leur candidature. Les candidats doivent être membres en règle de la Société.

Si le ou la candidate n'est pas élu(e) l'année de mise en candidature, il ou elle sera éligible pour les deux années suivantes.

Tous les membres, sauf les membres actuels du Conseil d'administration de la SCP, peuvent être mis en candidature au titre de fellow. Les membres ne peuvent pas se mettre eux-mêmes en candidature et les membres du Conseil d'administration actuels ne peuvent pas proposer de candidature. Comme il est indiqué dans le règlement, il y a trois façons d'obtenir le statut de fellow : 1) une contribution éclatante au développement scientifique de la psychologie; 2) une contribution éclatante au développement professionnel de la psychologie; et 3) un service exceptionnel aux associations nationales ou provinciales de psychologues.

Les mises en candidature doivent être faites de la façon suivante :

Les mises en candidature doivent inclure le curriculum vitae à jour de la personne en nomination et **au moins trois lettres d'appui** rédigées au cours de la dernière année civile par des fellows ou des membres actuels. Préférablement, les personnes qui font les mises en candidature devraient provenir de trois organismes différents, un seul au plus venant du même organisme que celui de la personne mise en candidature.

Les lettres de mise en candidature doivent être précises quant aux façons dont la recherche ou la pratique de la personne en nomination a contribué au développement scientifique ou professionnel de la psychologie ou aux façons dont le service de la personne à son association nationale ou provinciale de psychologues a été exceptionnel. Dans le cas de mises en candidature fondées sur des réalisations autres que de la théorie ou de la recherche publiée, les contributions novatrices précises et leur incidence sur la psychologie devraient être décrites.

Les lettres de mise en candidature devraient mettre en valeur la qualité des revues où la personne en nomination a publié, les prix qu'elle a reçus, etc. Dans le cas d'une mise en candidature fondée sur un service exceptionnel à son association nationale ou provinciale de psychologues, les lettres de mise en candidature devraient souligner la nature des associations (p. ex. la nature des associations, le nombre de membres, les services fournis, etc.).

Normalement, la personne mise en candidature devrait avoir terminé sa formation post-secondaire dix ans avant sa mise en candidature au titre de fellow. Une personne possédant moins de dix ans d'expérience après avoir obtenu son diplôme, mais plus de cinq années d'expériences, pourrait être élue fellow si sa contribution ou son service a été trouvé vraiment exceptionnel par le Comité.

Les mises en candidature doivent parvenir préférablement par courriel (en format PDF) au plus tard **LE 30 NOVEMBRE** et doivent être accompagnées du curriculum vitae du candidat ou de la candidate et **au moins trois lettres d'appui** à l'adresse suivante :

cpa@cpa.ca
Dr David Dozois
Président du Comité des fellows et des prix
Société canadienne de psychologie
141 avenue Laurier ouest, bureau 702, Ottawa, Ontario K1P 5J3

Veuillez consulter la liste des fellows actuels sur notre site web
http://www.cpa.ca/aproposdelascp/prixdelascp/fellows/

COMPOSITION ACTUELLE DU CONSEIL D'ADMINISTRATION

Présidente : Jennifer Frain, New Directions for Children, Youth, Adults & Family, Winnipeg, MB

Président sortant : David Dozois, University of Western Ontario, London, ON, Psychologie clinique

Président désigné : Wolfgang Linden, University of British Columbia, Vancouver, CB, Psychologie clinique

Directeurs dont le mandat se termine en 2013

Scientifique : John Meyer, University of Western Ontario, ON, Industrielle et organisationnelle

Scientifique-praticien – Mary Pat McAndrews, Toronto Western Hospital, ON, Neuropsychologie

Non désigné : Sylvie Bourgeois, GRC, Ottawa, ON, Psychologie de la santé

Non désigné – réservé à un(e) psychologue détenant une Maîtrise : Dawn Hanson, Winnipeg MB, pratique privée

Non désigné – réservé à un(e) psychologue engagé dans la recherche fondamentale : Aimée Suprenant, Memorial University, St. John's, NL

Directeur dont le mandat se termine en 2014

Praticien : Dorothy Cotton, Kingston, ON, Neuropsychologie, système de justice pénal

Directeur dont le mandat se termine en 2015

Non désigné – réservé à un(e) psychologue francophone: Marie-Hélène Pelletier, Vancouver, CB, pratique privée

Veuillez consulter notre site web pour prendre connaissance du règlement IX - Mise en candidature au http://www.cpa.ca/aproposdelascp/reglementsgeneraux/

ACADIA UNIVERSITY
Department of Psychology
Honours Thesis
Natasha Dienes
Jenna Dickson
Kristen Higgins
Masters Thesis
Kristen Bailey
Samantha Fizell
Michelle Valley

UNIVERSITY OF ALBERTA
Honours Thesis
Jordan Clemens
Rowan El-Bialy
Masters Thesis
Naheed Hosan
Lisa Smithson
Doctoral Thesis
Marc Avey
Cyrus Shaoul

BISHOP'S UNIVERSITY
Department of Psychology
Honours Thesis
Sarah Duguay
Julie Petrin
Kayla Smith

UNIVERSITY OF BRITISH COLUMBIA
Department of Psychology
Honours Thesis
Virginie Cousineau
Grace Qiao
Ashley Whillans
Masters Thesis
Mathew Dixon
Kostadin Kushlev
Natalie Miller
Doctoral Thesis
Lara Aknin
Jeremy A. Frimer
Carolin Klein

BROCK UNIVERSITY
Department of Psychology
Honours Thesis
Tamara Speth
Masters Thesis
James Desjardins
Stefon van Noordt
Jayne Morrish
Doctoral Thesis
Marie Good

UNIVERSITY OF CALGARY
Department of Psychology
Honours Thesis
Amy Hampton
Masters Thesis
Renata Godlewski
Kristin Newman
Laurel Wallace
Doctoral Thesis
Laura Labelle
Terri-Lynn MacKay
Roxanne Sterniczuk

UNIVERSITY OF CALGARY
Division of Applied Psychology
Masters Thesis
Jennifer Dahl
Michelle Gour
Sarah Knight
Doctoral Thesis
Jennifer Thannhauser

CAPE BRETON UNIVERSITY
Department of Psychology
Honours Thesis
Mariah E. MacKay
Kevin J. MacDonald
Meaghan C. Higgins

CARLETON UNIVERSITY
Department of Psychology
Honours Thesis
Ron Kozan
Geoffrey Plint
Jennifer Reed
Masters Thesis
Geoffrey Barnum
Brent Bezo
Kathleen Jubenville
Doctoral Thesis
Lindsay Berrigan
Julie Dempsey
Jennifer Thake

ST. MARY'S UNIVERSITY
Department of Psychology
Masters Thesis
Patrick Horsman
Luc Bourgeois
Timur Ozbilir
Doctoral Thesis
Jason Slaunwhite

ST. THOMAS UNIVERSITY
Department of Psychology
Honours Thesis
Jennifer Bennell
Michelle Boutilier
Daniella DaPonte

UNIVERSITY OF TORONTO SCARBOROUGH
Department of Psychology
Honours Thesis
Tharanky Balachandran
Matthew Quitasol
Matthew Wilmot

TRENT UNIVERSITY
Department of Psychology
Honours Thesis
Robert Aidelbaum
John Ben Blakey
Brittany Sirtonski

CONCORDIA UNIVERSITY
Department of Psychology
Honours Thesis
Thaisa Cotton
Stephanie Gallant
Diana Mihalache
Masters Thesis
Elana August
Hannah Levy
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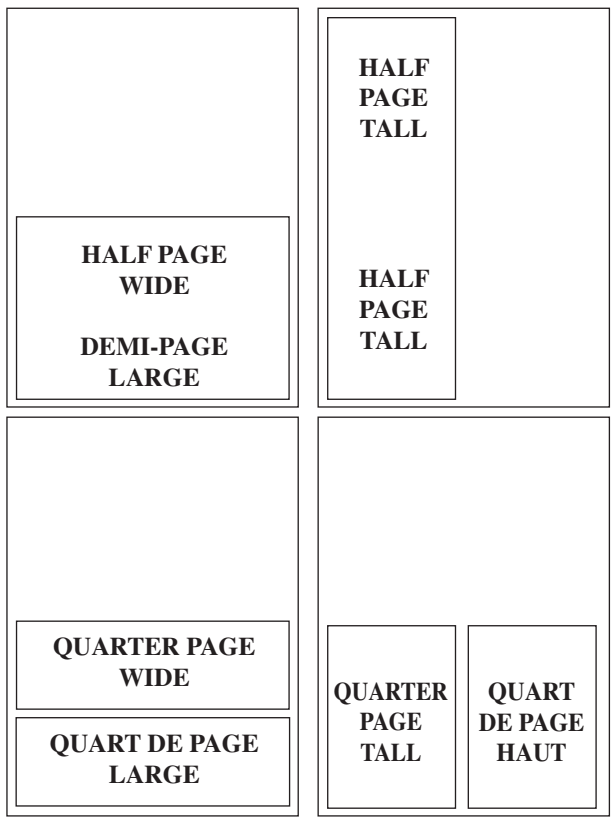

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Sharon Clark, PhD.; Debbie Emberly, PhD, IWK Health Centre, Halifax

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The psychological side of health: Innovations in service delivery for person with chronic conditions

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Relapse Prevention Following First Episode Psychosis

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Increasing access to therapist assisted internet cognitive behaviour therapy in Saskatchewan: A description of the Online Therapy Unit for Service, Education, and Research

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Partnering Hospital Services and Community Therapists for People with Borderline Personality Disorder: Dialectical Behaviour Therapy 'Lite'

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A Positive Psychology Approach to Education for At-Risk High School Youth

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Treating Insomnia in Primary Care:
A Key Role for Psychologists

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Providing Psychological Services and Training in Primary Care: Ryerson University and St. Michael's Hospital

Jen Rouse, MA, Kelly McShane, PhD, & Candice Monson, PhD Ryerson University

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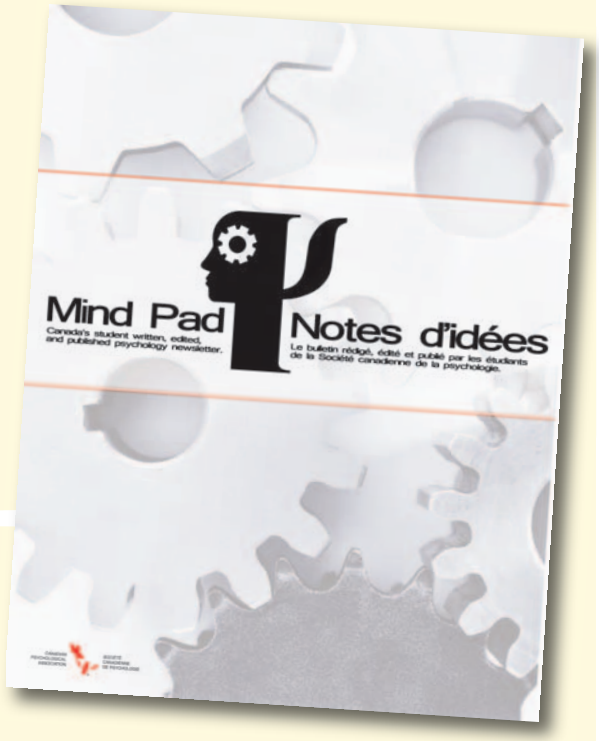
Dear students and psychology faculty,

The CPA student section is proud to present *MindPad*, the Student Sections' latest endeavour! It is a student written and reviewed newsletter. *MindPad* aims to publish material that is of interest to all who are practicing and studying psychology, but targets students in particular. **Our second issue is now available at http://www.cpa.ca/docs/File/Students/MindPad/mindpadSpring2012/.** You will find articles as diverse as our students. Topics explored are those of language comprehension impairments and psychosis, an examination of cross-cultural gender counselling and the role of psychologists in an aging Canadian population.

MindPad offers students the opportunity to experience both the writing and the formal reviewing process that every psychologist (and psychologist in training!) must navigate. *MindPad* is a platform for discussion and learning. I encourage you to support our section and students by submitting your comments to the articles or by your sending in your own submission! For more information on *MindPad* and the submission process, please visit **www.cpa.ca/students/MindPad.**



Rana Pishva MSc.
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À tous les étudiants et professeurs de psychologie

La section des étudiants de la SCP est fière de vous présenter *Notes d'idées*, la dernière entreprise de la section des étudiants! Il s'agit d'un bulletin écrit et révisé par les étudiants. *Notes d'idées* vise à publier du matériel qui intéresse tous ceux qui pratiquent et étudient la psychologie, mais cible tout particulièrement les étudiants. **Vous pouvez maintenant trouver notre deuxième numéro à l'adresse http://www.cpa.ca/docs/File/Students/MindPad/mindpadSpring2012/.** Vous trouverez des articles d'une diversité aussi grande que celle de nos étudiants. Les sujets explorés sont ceux des déficiences dans la compréhension du langage et les psychoses, un examen du counseling des genres interculturels et le rôle des psychologues dans la population vieillissante canadienne.

Notes d'idées offre aux étudiants la possibilité de s'exercer à la rédaction et de se frotter au processus de révision officiel comme le font tous les psychologues (et les psychologues en formation!). *Notes d'idées* est une tribune pour la discussion et l'apprentissage. Je vous encourage à appuyer notre section et les étudiants en présentant vos commentaires sur les articles ou en nous faisant parvenir vos propres articles! Pour plus d'information sur *Notes d'idées* et le processus de présentation d'articles, veuillez vous rendre à l'adresse **www.cpa.ca/students/MindPad.**

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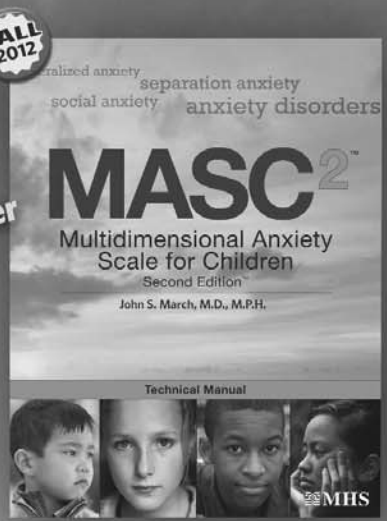

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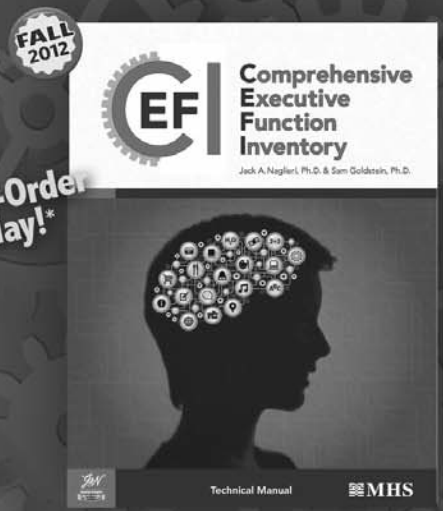

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