

PSYNOPSIS

CANADA'S PSYCHOLOGY MAGAZINE | LE MAGAZINE DES PSYCHOLOGUES DU CANADA

Disability in Canada The Role for Psychologists

L'incapacité au Canada Le rôle des psychologues

Jamie MacDougall, C.M., Ph.D., C.Psych.,
Guest Editor/Rédacteur en chef invité



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LONG TERM DISABILITY:

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Long term disability (LTD) insurance is supposed to be a safety net. Your patients are ill or injured and expect that their LTD insurers will step up and help them when they can't work. After all, that's the whole point of having insurance, right?

But what happens if one of your patients applies for LTD and is denied? What happens if they are cut off prematurely? What if the insurance company's doctors say that your patient is able to work when in reality they cannot?

LTD claims involving mental illness or disability are often treated unfairly by insurers. The insurance company may simply choose to ignore your opinion that your patient is in fact suffering and cannot work.

The stigma and prejudice shown by insurance companies can be fought by legal means. Insurers who summarily dismiss mental illness as a valid basis for LTD have been proven wrong time and time again in court. The key is to understand how insurers operate and what is needed in order to level the playing field.



Sivan Tumarkin
Disability Lawyer

Benefits of a Legal Team

My team and I deal with the insurance company directly on behalf of the disabled individual. Your patient and their family no longer receive taxing calls, letters or emails from the insurance adjuster.

Treatment providers are also relieved because we bridge the gap between mental health professionals and insurance companies. Treatment providers are compensated for their time spent preparing necessary reports that are used to support their patients' LTD claims. LTD claims are not difficult to resolve with the right legal team. As a former insurance defence lawyer, I can tell you that insurance companies are not in the business of fighting legitimate claims.

3 Common Reasons Insurers Deny LTD Claims

1 Not "Totally Disabled"

The insurer simply concludes that your patient is not "totally disabled" as defined by the policy. It is not difficult to refute such a denial with your help.

2 Insufficient Documentation

This frustrating reason for denial demonstrates a complete disregard for your professional opinion that your patient is in fact unable to work. Detailed reports addressing your patient's disability and prognosis will counter this.

3 Not Following Treatment

Failure by patients to follow recommendations (missing appointments, etc.) often has a reasonable explanation. The key is providing context for the patient's behaviour.

3 Tips for Helping Your Patients with Their LTD Claims

1 Detailed Reports

Your reports to the insurer must be detailed and explain what exactly is preventing your patient from returning to work, along with your prognosis and recommendations for treatment.

2 Regular Treatments

Without regular treatments, the insurer will likely take the position that either the disability is not severe enough to warrant treatments and time off work, or that the individual has failed to mitigate damages or improve their health.

3 Empower Your Patient

In addition to treating your patients, you can tell them that there are legal experts that can help with their LTD claims. We often advise mental health professionals on how to deal with LTD insurers and their patients.

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Disability in Canada

The Role for Psychologists

Jamie MacDougall, C.M., Ph.D., C.Psych., Director of Rehabilitation Research, The Ottawa Hospital Rehabilitation Centre

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) estimates that 195 million persons worldwide have a sensory, physical, or mental disability that impacts activities of daily living.¹ Statistics Canada reports that 3.8 million adult Canadians are limited in their daily activities due to a disability.² There is little doubt that disability touches the lives of many Canadians either directly or indirectly. This special issue of *Psynopsis* reviews

current developments in the disability field from a political/policy perspective, and highlights the disability-related work of selected Canadian psychologists.

Following the 2015 federal election, Prime Minister Justin Trudeau made history by naming a Minister specifically responsible for the disability file. Carla Qualtrough was named Minister of Sport and Persons with Disabilities* and given the mandate to develop a Canadians with Disability Act (Accessible Canada).³

*The Honourable Carla Qualtrough has since been sworn in as Minister of Public Services and Procurement.

In the opening article of this issue, Minister Qualtrough outlines the many barriers faced by Canadians with a disability and the impact that negative stereotypes and stigma have for full inclusion and participation in society. She explains that the new Act will be directed toward areas of federal jurisdiction such as federal banks, federal telecommunications, interprovincial travel, and federal government employers. While these are important areas, many of the barriers that persons with disability face fall under provincial or local jurisdiction. And though certain provinces already have legislation in place, such as the Accessibility for Ontarians with Disability Act,⁴ this level of legislation lacks teeth for enforcement in many cases. In the development of the federal Act, advocates from the disability community are pushing for legal enforcement of identified accommodation measures, which do not currently exist at the provincial level.

An important aspect of developing the Accessible Canada Act involved carrying out national consultations across the country to evaluate the experiences and concerns of persons with disability (and their networks of family and friends) that should be addressed in the new Act. I was honored to act as the local champion for the Ottawa consultation, where I heard first-hand the opinions and many frustrations of persons with disability, across a wide range of age, gender, and ethnic identities. Hearing these moving accounts of the struggles persons with disability continue to face in Canadian society revealed that, despite many advances in the past few decades, much remains to be done.

Psychologists have an important role to play in developing strategies to improve this situation, and in this regard, can contribute in significant ways to improving the quality of life of persons with disability. In her article, Pontefract takes up this theme and shows why, from both a professional and a personal perspective, disability should matter to psychologists. Based on her experience at the Ottawa Hospital Rehabilitation Center, she emphasizes the importance of a holistic approach to treatment involving multi-disciplinary teams. Therapy is not enough, and special accommodations such as physical accessibility and adapted transport need to be considered for institutionally based services, as well as in private practice settings. Pontefract does not stop there, urging psychologists to become involved with advocacy, whether at the level of policy discussion or on the front lines dealing with more general issues involving public perception and respect for available accommodations (such as respecting signs for reserved parking for persons with disability).

A good example illustrating the need for special accommodations to be an integral part of psychological services, is given by Chovaz, who specializes in mental health services for deaf children and adults. She focuses on a special group of

people with hearing loss who do not consider themselves as being disabled, rather, they are members of a unique culture (Deaf culture) characterized by use of sign language and shared social dispositions. Chovaz stresses the need for qualified and experienced psychologists to work with Deaf people. Of singular importance is the need for sign language interpretation in the delivery of mental health services, as mandated by the 1997 Eldridge Supreme Court decision.

It is important to note that many Canadian psychologists carry out specialized work with deaf children and adults who do not use sign language, and who rely primarily on speech and hearing for communication. For a review of the long-standing debate between oral and signed approaches toward deaf education, a list of key sources discussing the communications controversy is given in the reference list.

Another issue frustrating both professionals and persons with disability themselves (as noted in the recent national public consultations) is the relative lack of innovative approaches that are available to address the unmet needs of persons with physical, sensory, or mental disabilities. In this context, there is a pressing need to innovate and develop new approaches.

One such novel therapy, called Equine-Based Therapy, is reviewed by Goodwin, Davey and Barnfield. Their article reviews the three types of therapy currently in use, emphasizing the benefits of adopting a holistic approach. These authors stress the need for specialized training for therapists who follow the Canadian Therapeutic Riding Association (CANtra) standards and for additional empirically based research. This innovative model experiments with new approaches, while ensuring that any new therapies offered are consistent with empirical evidence and carried out by professionally-qualified practitioners.

An important area of disability that has attracted the attention of Canadian psychologists, from both a research and a clinical perspective, is the area of chronic pain. Ron Melzack's groundbreaking work in pain is well known in the psychology community.⁵ It is noteworthy that one of Melzack's graduate students, John Okeefe, was recently awarded the Nobel Prize in Medicine.⁶

Two leading pain researchers, Sullivan and Craig, offer their perspectives on chronic pain in this issue. Craig's article is a *cri de coeur* for increased effort on the part of psychologists in chronic pain research and therapeutic practices. He highlights the profound impact chronic pain has on the lives of millions of Canadians, explains the far-reaching effects that suffering has for individuals and families in economic and social terms, and points to the profound impact of chronic pain on utilization of resources in the health care system. He advances a new definition of chronic pain that emphasizes the importance of biopsychosocial factors, exposing the shortcomings of relying on narrow

Psychologists have an important role to play in developing strategies to improve this situation, and in this regard, can contribute in significant ways to improving the quality of life of persons with disability.

biomedical models and suggests that psychologists are uniquely positioned to make a difference in the field.

Sullivan, on the other hand, picks up on the importance of psychological factors in chronic pain, detailing issues related to work-disability following from injury. As he points out, successful return-to-work is a key indicator of successful rehabilitation. However, narrowly medically-focused interventions, such as opioid use, have clearly not been successful in treating this type of chronic pain. Based on two decades of research, Sullivan shows that pain-related psychosocial interventions provide an essential aspect of holistic approaches toward rehabilitation. He laments the relative absence of pain-related training opportunities for psychologists, and suggests that service agencies and health care facilities should be reconfigured to take into consideration the potential of psychosocial approaches. Indeed, this important observation concerning lack of training opportunities for psychologists is relevant to the entire field of disability.

The Truth and Reconciliation Commission of Canada has specified disability as a priority area for action for all Indigenous people – First Nations, Inuit, and Metis.⁷ There is an urgent need for engagement by psychologists in the area of Indigenous disability.⁸ The CPA has an excellent section on Aboriginal (Indigenous) Psychology, and I strongly recommend that any psychologist proposing to work in the field of Aboriginal/Indigenous disability contact the section to ensure cultural sensitivity and competence.⁹

This is an exciting time in Canada for all aspects of disability. Canada has signed on to the far-reaching United

United Nations CRPD, and a new disability Act (Accessible Canada) is being developed. Whether through innovative research, the provision of public or private services, or public advocacy, Canadian psychologists clearly have a pivotal role to play.

I am confident that we will do our part in breaking down barriers to ensure the inclusion and participation of all Canadians in society. However, let us do so while keeping in mind the following statement by participants in the national disability consultations: “nothing about us without us.”¹⁰ In this context, it is imperative that we listen carefully to persons with disabilities as we continue to provide needed services within the evolving human rights context that guides disability policy in Canada.

Jamie MacDougall has been the Director of Rehabilitation Research at the Ottawa Hospital Rehabilitation Center for 30 years. He is also an Associate Professor in the Faculty of Medicine at the University of Ottawa, a Senior Mental Health and Research consultant to the Bob Rumball Center of Excellence for the Deaf, and President and CEO of the Canadian Deafness Research and Training Institute based in Montreal. In 2003, he was inducted into the Terry Fox Hall of Fame, and in 2010, he became a member of the Order of Canada.



For a complete list of references, please go to www.cpa.ca/psynopsis

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L'incapacité au Canada

le rôle des psychologues



Jamie MacDougall, C.M., Ph. D., C.Psych., directeur de la recherche en réadaptation, Centre de réadaptation de l'Hôpital d'Ottawa

La Convention relative aux droits des personnes handicapées (CDPH) estime à 195 millions le nombre de personnes dans le monde qui présentent un handicap sensoriel, physique ou mental qui a des répercussions sur les activités de la vie quotidienne¹. Selon Statistique Canada, 3,8 millions de Canadiens adultes sont limités dans leurs activités quotidiennes à cause d'une incapacité². Il est donc évident que l'incapacité affecte, directement ou indirectement, la vie de nombreux Canadiens. Le présent numéro spécial de

Psynopsis présente l'évolution actuelle des connaissances dans le domaine de l'incapacité, du point de vue politique et sous l'angle des politiques, et met en lumière les travaux liés à l'incapacité menés par des psychologues canadiens.

À la suite de l'élection fédérale de 2015, le premier ministre Justin Trudeau a écrit une page d'histoire en nommant une ministre spécialement chargée du dossier des personnes handicapées. Nommée ministre des Sports et des Personnes handicapées, Carla Qualtrough* s'est fait confier le mandat d'élaborer une loi sur l'accessibilité pour les Canadiens handicapés (Canada accessible)³.

* L'honorable Carla Qualtrough a depuis été assermenté en tant que Ministre des Services publics et de l'Approvisionnement.

Dans le premier article de ce numéro, la ministre Qualtrough souligne les nombreux obstacles auxquels font face les Canadiens handicapés et les répercussions qu'ont les stéréotypes négatifs et la stigmatisation sur leurs pleines intégration et participation à la société. Elle explique que la nouvelle loi sera orientée vers les domaines de compétence fédérale, comme les banques fédérales, les télécommunications fédérales, les voyages interprovinciaux et les employeurs du gouvernement fédéral. Bien qu'il s'agisse de domaines importants, un grand nombre d'obstacles auxquels les personnes handicapées sont confrontées sont de compétence provinciale ou locale. Et bien que certaines provinces aient mis en place des lois relatives aux personnes handicapées, comme la *Loi sur l'accessibilité pour les personnes handicapées de l'Ontario*⁴, dans de nombreux cas, ces lois manquent de moyens concrets lorsqu'il s'agit de leur exécution. Dans le cadre de l'élaboration de la loi fédérale, les défenseurs du milieu des personnes handicapées font pression en faveur de l'obligation juridique d'accorder les mesures d'adaptation identifiées, qui n'existent pas actuellement à l'échelle provinciale.

Un aspect important de l'élaboration de la loi canadienne sur l'accessibilité implique la réalisation de consultations nationales à la grandeur du pays dans le but d'évaluer les expériences et les préoccupations des personnes handicapées (et de leurs réseaux d'amis et leur famille) que la nouvelle loi devrait prendre en compte. J'ai eu l'honneur d'agir à titre de champion local de la consultation d'Ottawa, ce qui m'a donné la chance d'entendre les points de vue de personnes handicapées de tous âges, sexes et appartenances ethniques, ainsi que les nombreuses frustrations qu'elles vivent. Les récits émouvants des combats que doivent mener encore aujourd'hui les personnes ayant une limitation fonctionnelle dans la société canadienne révèlent que, même si de nombreux progrès ont été réalisés au cours des dernières décennies, il reste beaucoup à faire.

Les psychologues ont un rôle important à jouer dans l'élaboration de stratégies visant à améliorer la situation, et ils peuvent, à cet égard, contribuer de manière significative à améliorer la qualité de vie des personnes handicapées. Dans son article, Pontefract reprend ce thème et montre pourquoi, tant sur le plan professionnel que personnel, les psychologues devraient s'intéresser à l'incapacité. En s'appuyant sur son expérience au Centre de réadaptation de l'Hôpital d'Ottawa, elle souligne l'importance des approches thérapeutiques

holistiques qui mettent à contribution des équipes multidisciplinaires. La thérapie ne suffit pas, et les établissements publics et les cabinets privés qui dispensent des services doivent prévoir des aménagements particuliers, comme l'accessibilité physique des lieux et le transport adapté. Pontefract ne s'arrête pas là et exhorte les psychologues à s'impliquer dans la défense des droits des personnes handicapées, que ce soit dans le débat politique ou aux premières lignes, en s'occupant de questions générales concernant la perception du public et le respect des aménagements disponibles (comme le respect de la signalisation sur les panneaux de stationnement pour personnes handicapées).

Un bon exemple de la nécessité d'intégrer les aménagements spéciaux aux services psychologiques est fourni par Chovaz, qui se spécialise dans les services de santé mentale pour les enfants et les adultes sourds. La clientèle de la D^{re} Chovaz est constituée de personnes qui souffrent d'une perte auditive, mais qui ne se considèrent pas comme des personnes handicapées, mais plutôt comme les membres d'une culture unique (la culture sourde), laquelle se caractérise par l'emploi de la langue des signes et par des dispositions sociales communes. Chovaz souligne le besoin de psychologues qualifiés et expérimentés pour travailler avec les personnes sourdes. L'interprétation en langue des signes dans la prestation des services de santé mentale, comme l'a décrété la Cour suprême, en 1997, dans l'affaire Eldridge, est selon elle particulièrement importante.

Il est important de mentionner que de nombreux psychologues canadiens offrent des services spécialisés aux enfants et aux adultes sourds qui n'utilisent pas la langue des signes, et qui se servent principalement de l'ouïe et de la parole pour communiquer. Pour avoir une vue d'ensemble du débat de longue date qui oppose l'utilisation de la langue orale et de la langue signée dans l'éducation des personnes sourdes, se reporter aux principales sources qui traitent de cette question controversée, fournies dans la liste de références.

L'absence relative de méthodes novatrices disponibles pour répondre aux besoins des personnes ayant une incapacité physique, sensorielle ou mentale est un autre problème frustrant auquel se butent à la fois les professionnels et les personnes handicapées elles-mêmes (comme le révèlent de récentes consultations publiques nationales). Dans ce contexte, il est urgent d'innover et de développer de nouvelles méthodes.

Les psychologues ont un rôle important à jouer dans l'élaboration de stratégies visant à améliorer la situation, et ils peuvent, à cet égard, contribuer de manière significative à améliorer la qualité de vie des personnes handicapées.

L'une de ces thérapies nouvelles, appelée thérapie par le cheval, est examinée par Goodwin, Davey et Barnfield. Leur article passe en revue les trois types de thérapie utilisés en ce moment, en soulignant les avantages de l'approche holistique. Ces auteurs insistent sur le besoin de formation spécialisée pour les thérapeutes qui suivent les normes de l'Association canadienne d'équitation thérapeutique (ACET) et sur l'importance de mener d'autres recherches fondées sur des données empiriques. Ce modèle novateur met à l'essai de nouvelles approches, tout en veillant à ce que les nouvelles thérapies offertes soient conformes aux données empiriques, et prodiguées par des praticiens qualifiés.

La douleur chronique est un aspect important du handicap qui attire l'attention des psychologues canadiens, tant du point de vue clinique que du point de vue de la recherche. Le travail novateur de Ron Melzack dans le domaine de la douleur est bien connu dans le milieu de la psychologie⁵. Il est important de mentionner que l'un des étudiants diplômés du Dr Melzack, John Okeefe, a reçu récemment le Prix Nobel de médecine⁶.

Dans le présent numéro, deux chercheurs éminents dans le domaine de la douleur, Sullivan et Craig, font part de leurs points de vue sur la douleur chronique. Dans son article, Craig lance un cri du cœur exhortant les psychologues à faire plus de recherche sur la douleur chronique et à perfectionner leurs pratiques thérapeutiques. Il met en évidence les répercussions profondes qu'a la douleur chronique sur la vie de millions de Canadiens, explique les effets considérables de la souffrance sur les individus et leur famille du point de vue économique et social et souligne l'impact énorme de la douleur chronique sur l'utilisation des ressources dans le système de soins de santé. Il propose une nouvelle définition de la douleur chronique, qui met l'accent sur l'importance des facteurs biopsychosociaux, exposant les lacunes de la dépendance aux modèles biomédicaux restrictifs, et laisse entendre que les psychologues sont particulièrement bien placés pour innover et changer les choses dans ce domaine.

Sullivan, en revanche, revient sur l'importance des facteurs psychologiques dans la douleur chronique en exposant en détail les questions liées à l'incapacité de travail à la suite d'une blessure. Comme il le souligne, la réussite du retour au travail est un indicateur clé de la réussite de la réadaptation. Cependant, les interventions strictement médicales, comme l'usage d'opioïdes, ne réussissent manifestement pas à traiter ce type de douleur chronique. En s'appuyant sur deux décennies de recherche, Sullivan montre que les interventions psychosociales pour le traitement de la douleur constituent un élément essentiel des approches holistiques de la réadaptation. Il déplore l'absence relative de possibilités de formation sur la douleur offertes aux psychologues, et indique que les organismes de services et les

établissements de soins de santé devraient être reconfigurés pour prendre en compte le potentiel des approches psychosociales. En effet, cette observation pertinente sur le manque de possibilités de formation pour les psychologues s'applique à l'ensemble du domaine du handicap.

La Commission de vérité et réconciliation du Canada a désigné l'incapacité comme un domaine prioritaire d'action pour l'ensemble des peuples autochtones, à savoir les Premières Nations, les Inuits et les Métis⁷. Il est urgent que les psychologues s'impliquent dans le domaine de l'incapacité chez les Autochtones⁸. La section de la SCP qui se consacre à la psychologie des autochtones est très active, et j'encourage fortement les psychologues qui s'intéressent à l'incapacité chez les Autochtones et veulent prendre part aux travaux dans ce domaine à communiquer avec la section pour promouvoir la sensibilité aux réalités culturelles et les compétences culturelles⁹ dans notre profession.

Il se passe beaucoup de choses intéressantes au Canada dans le domaine de l'incapacité et du handicap. Le Canada a signé la CDPH tandis qu'une nouvelle loi sur l'accessibilité pour les personnes handicapées (Canada accessible) est en cours d'élaboration. Que ce soit par la voie de recherches novatrices, de la prestation de services publics ou privés ou de la défense des intérêts, les psychologues canadiens ont nettement un rôle central à jouer.

Je suis persuadé que nous contribuerons à éliminer les obstacles de manière à assurer l'inclusion et la participation de tous les Canadiens à la société. Mais n'oublions pas ce qu'ont dit les participants des consultations nationales sur l'incapacité : « Rien pour nous sans nous »¹⁰. Dans ce contexte, il est impératif d'écouter attentivement les personnes handicapées tout en continuant à offrir les services dont elles ont besoin, dans le contexte de l'évolution des droits de l'homme, qui guide les politiques sur les personnes handicapées au Canada.

Jamie MacDougall est le directeur de la recherche en réadaptation du Centre de réadaptation de l'Hôpital d'Ottawa depuis 30 ans. Il est également professeur agrégé à la Faculté de médecine de l'Université d'Ottawa, conseiller principal en santé mentale et en recherche au Bob Rumball Center of Excellence for the Deaf et président et chef de la direction de l'Institut canadien de recherche et de formation sur la surdité, établi à Montréal. Intrônisé en 2003 au Temple de la renommée Terry Fox, il est devenu membre de l'Ordre du Canada en 2010.



Pour la liste des références, voir www.cpa.ca/psynopsis

An accessible Canada includes **all people** with disabilities



*The Honourable Carla Qualtrough,
Minister of Sport and Persons with Disabilities**

When we talk about disabilities and accessibility, we often think of physical disabilities or impairments to the senses. Most often, this includes people who have hearing or sight impairments, or people who require a wheelchair for everyday mobility. What we often leave out are those invisible disabilities that are rooted in mental illness or stem from mental health issues.

While everyone experiences changes in their thoughts and feelings from time to time, psychological disabilities such as depression, anxiety, schizophrenia, and bipolar disorder can be debilitating to varying degrees. Just like any physical disability, these invisible disabilities can affect our

relationships, work, health, learning, and self-care.

In my mandate letter from Prime Minister Trudeau, as Canada's first minister responsible for persons with disabilities, I was tasked with leading an engagement process to establish new legislation that will make Canada more accessible. Since I started this process in fall 2016, I've heard from young Canadians who want equal access to education, from parents with dreams of their children being self-sufficient when they grow up, and from people who face discrimination in their workplace. Everyone had a unique story to tell, but there was one common theme: people with disabilities face barriers that limit their inclusion in society.

Participants made it clear that anything that prevents or limits people with disabilities from being fully included should be considered a "barrier to accessibility." This includes both physical and non-physical barriers.¹

*The Honourable Carla Qualtrough has since been sworn in as Minister of Public Services and Procurement.

One of the most persistent and troubling barriers for people with disabilities is the stigma they face, and the issue can be more complex for people with invisible disabilities. While we are in the early stages of developing new legislation, we know it needs to address not only barriers to physical accessibility, but also to those “unseen barriers”—the ones that make some people feel as though they need to hide their disability, like stigma.

People should feel confident when disclosing their disability that they will be treated fairly and equitably, and that they will receive adjustments as needed.

Currently, addressing accessibility issues on the federal level is done after the fact. People with disabilities can only defend their rights after experiencing discrimination, by filing a complaint with either their provincial or federal human rights commission. It’s worth noting that more than half of all the discrimination complaints received by the Canadian Human Rights Commission between 2011 and 2016 were disability-related. Of those, a significant number are related to mental health issues. For example, in 2016, 60% of the complaints received by the Commission were related to disability. Almost half of these, 48% to be precise, were related to mental health issues.²

The intent of the new legislation will be to proactively address the common barriers people with disabilities face in their daily lives. At its core, this new law will aim to do two

things: increase the inclusion and participation of all Canadians in society and promote equality of opportunity by removing barriers in areas of federal jurisdiction. The new legislation will apply to all companies that operate under federal jurisdiction—including federal banks, federal telecommunications companies, interprovincial travel services, and federal government employers.

With public consultations now closed, we’re looking at everything we’ve learned in conjunction with what we’re hearing from stakeholders and the groups that represent them, as well as international and domestic best practices.

The new legislation will mark a shift for accessibility in Canada. It will help to proactively break down some of the barriers to accessibility at the federal level, while demonstrating leadership in improving the lives of people with disabilities.

But legislation isn’t enough. We need to change the way we think, talk and act when it comes to disability—visible and invisible—thereby leaving the stigma behind. Because when we talk about accessibility for people with disabilities, what we’re really talking about is creating an inclusive society where all Canadians have an equal opportunity to succeed, and are equal participants.

That is what an accessible Canada is all about.

For a complete list of references, please go to www.cpa.ca/psynopsis



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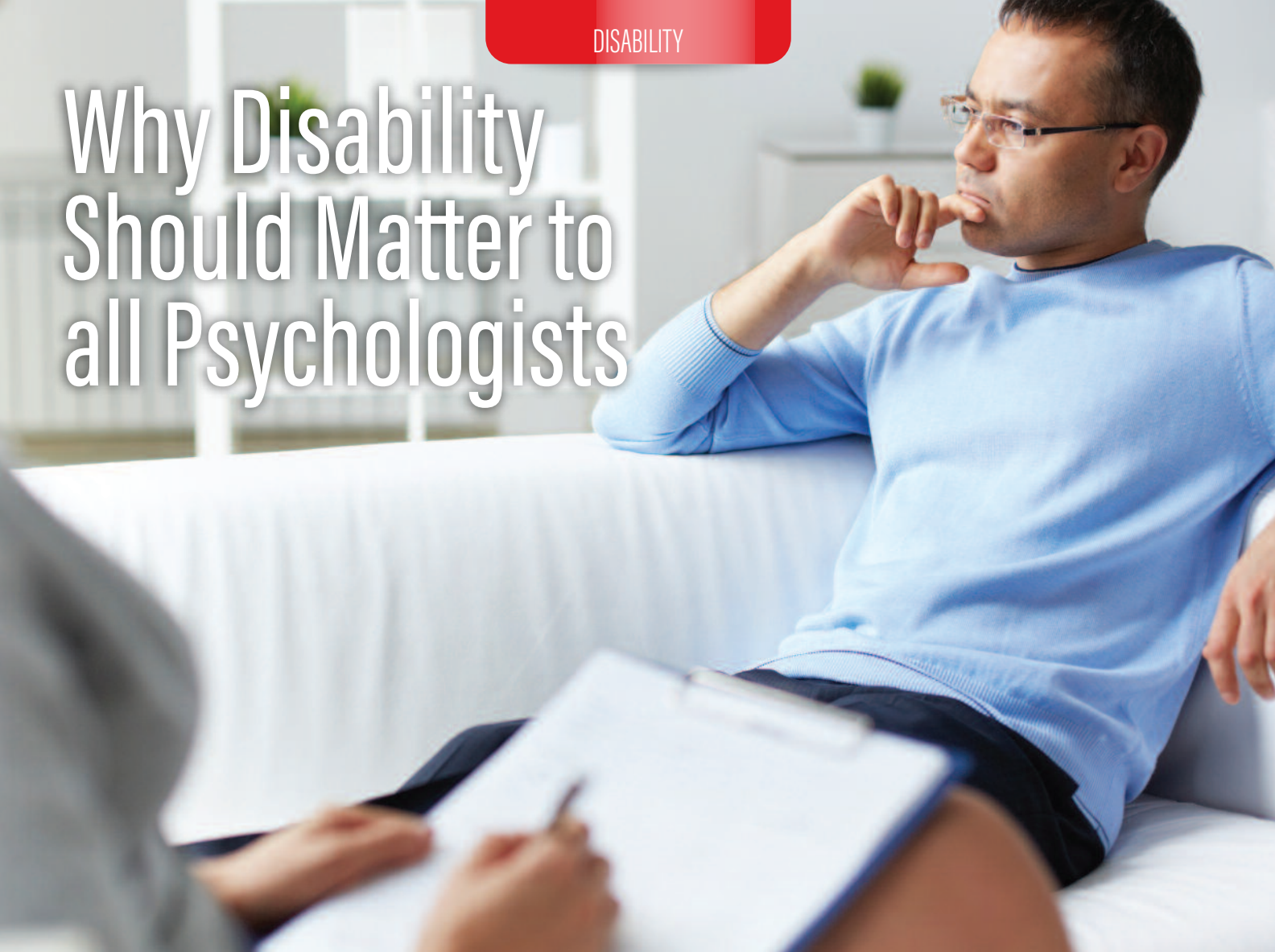
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Why Disability Should Matter to all Psychologists



Amanda Pontefract, Ph.D., Profession Leader for Psychology, The Ottawa Hospital

I first began to truly think about what it means to have a disability during my internship at the Royal Ottawa Health Care Group (ROHCG) in 1998. As part of the internship, I completed a six month rotation at the Ottawa Rehabilitation Centre, which was part of the ROHCG.

I quickly became exposed to individuals experiencing physical disability due to chronic illness, such as multiple sclerosis, or injury, such as traumatic amputation or spinal cord injury. I learned a tremendous amount about the work to be done from an impressive group of dedicated health professionals as well as from clients who were willing to be patient with me. The most valuable lesson I learned was that individuals with disability belong to one of the largest minority groups.

Why should this matter to all psychologists? The number of individuals living with disability in Canada is high. Aging can result in new disability or increased disability, and at

some point, many of us will be working with these individuals in our psychology practices.

The Environment Matters

As psychologists, we believe it is essential to be sensitive to the issues and challenges faced by our clients. However, in our efforts to treat individuals with disability without bias, we can easily miss the basics. I recall that in 2005, when I was a junior psychologist working at the Ottawa Hospital Rehabilitation Centre, we set out to develop a list of psychologists in our region with accessible offices and a declared interest in working with individuals with chronic illness or disability. Using a standard set of questions, we inquired about the degree of accessibility of their practices. Most psychologists described their offices as accessible; even those without access to washrooms or with a few stairs. Our most basic needs are tied to our sense of dignity, yet dignity is something many individuals with disability struggle to maintain.

It's Harder to Belong

I am acutely aware of how challenging it can be for individuals with disability to navigate a sidewalk in a wheelchair. In close to 20 years since my internship days, I have never looked at a curb cut in the same way. These environmental barriers have an impact beyond physical limits. Consider the challenges to browsing in shops with large aisle-blocking displays, joining friends at a restaurant or in accessing a public washroom. Add the obstacle of snow and ice found in Canadian winters to the equation, and one can begin to understand the social isolation that can come from living with disability.

Reliability is a Culturally Loaded Term

Individuals who rely on accessible public transit or the generosity of others, may not always be able to control their arrival time at destinations, and sometimes previously arranged transportation can fall through altogether. Clients may also be too unwell to attend appointments, or may be late because personal care is taking longer than expected. Can the client be recognized as reliable if they let you know that they will be late today, or simply can't make it to the session?

Same or Different? Just Ask

I learned early on to check with clients and ask them about the nature of their disability,¹ rather than assume I fully understood their experience. As a starting point, it was important for me to do my homework and have a basic understanding of a particular disability or chronic condition. However, disability can vary tremendously, even within the same medical condition, so I learned to invite patients to share

their own expertise, and to tell me if they consider a particular issue to be related to their disability.

For example, dating issues can be the same for someone with or without a disability, or they can be very different. Does an individual have issues around incontinence or limited genital sensation that increases feelings of vulnerability in starting a new relationship? Would an able-bodied individual be interested in them? Our own beliefs about disability can affect how we understand our client's fears as well as their potential to engage in a positive relationship. Early on, I learned a lot about my pre-existing biases about living with disability. I found this to be an important step in recognizing the whole person, and essential to doing meaningful therapeutic work.

Disability Matters Outside of the Office

I consider my experience working with individuals with disability as pivotal to both my professional and personal development. I recognize small opportunities to advocate for the rights and dignity of the disabled in the "everyday." I have been known to approach and educate drivers who are inappropriately parked in a disabled parking spot, or speak to a store about their obstructive displays. My adolescent children have said that my outspoken ways are embarrassing; however, in discussions, I take pride in knowing that they have each developed a respect for individuals living with disability. The lessons I learned in working with individuals with disability clearly apply across multiple spheres. For these lessons, I am forever grateful.

For a complete list of references, please go to www.cpa.ca/psynopsis



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Mental Health Care of Deaf People

Cathy Chovaz, Ph.D., C.Psych., Associate Professor of Psychology and Director, CDEAF, Kings University College

Many clinicians work with clients who don't hear well. These clients may be young children with ear infections, youth with noise-induced hearing loss, or perhaps elderly people with age-related changes. These hard of hearing people typically benefit from hearing aids, and in a quiet environment, may manage auditory communication (i.e. the use of voice, residual hearing, and hearing aids and other amplification devices), albeit with challenges. But not as many clinicians work with the segment of the Canadian population who are Deaf.

From a strictly medical perspective, people are considered deaf when there is little or no functional hearing and when that person depends on visual rather than auditory communication. Visual means of communication usually

refers to: sign language, lipreading, speech-reading, and reading and writing.

Seem straightforward? Quite the opposite. This is actually a very complex group of individuals who are not typically well understood by mainstream clinicians. And unfortunately, this lack of understanding contributes to the oppression and marginalization of this segment of the Canadian population and leads to ineffective delivery of mental health care services.

Consider the fact that the above definition is largely based on the medical viewpoint. This medicalization of deafness means an individual is defined and subsequently labelled mostly by the measurement of decibel loss. Though this definition may help to accurately prescribe effective hearing aid amplification or other devices, it is a very narrow view of the thousands of culturally Deaf Canadians who consider themselves "Deaf." It has been difficult to accurately assess population numbers as in the past many Deaf people have not

completed census forms or have not wished to self-identify themselves. The capitalization of the word “Deaf” denotes a sociocultural community characterized by a sign language, distinct values, norms, traditions, and a unique culture.¹ From this perspective, there is no wrong to be fixed by the medical community, but instead a life to be lived with pride that is inherently different from the majority hearing experience.

When working with this unique group, it is important to consider that studies have suggested a higher prevalence of mental health disorders in d/Deaf individuals than in hearing individuals. For example, it has been reported that children with early onset, severe to profound deafness in the UK were more vulnerable to mental health problems than their hearing peers.² The key risk factors identified were developmental delays associated with early communication deprivation, ineffective family communication, central nervous system disorders associated with specific causes of deafness, and abuse. It has also been reported that emotional/behavioural problems in deaf Dutch children were nearly 2.6 times higher than hearing children,³ and that Deaf people have a higher rate of mental health problems than the general population.⁴ It should be noted that d/Deaf individuals experience the same risk factors for developing mental health problems as the general population, but many of these factors are heightened by neurological, psychological, and social risk factors in addition to a vulnerability to abuse in childhood.⁵ Deafness or hearing loss itself does not cause mental health disorders but may be associated with other significant risk factors.

How should this increased prevalence rate of mental health disorders then be addressed by clinicians?

Best practices indicate that mental health professionals should recognize this subset of Canadians as a specialized group requiring specialized and experienced care. If the clinician is not fluent in American Sign Language (ASL) or Langue des Signes Québécoise (LSQ), the two predominant sign languages used in Canada, the services of a qualified interpreter should always be used. Family members should never be used as interpreters as this may change the accuracy or intent of information and important issues could be missed or misunderstood. This is especially true in those situations where the hearing parent may not actually share fluency in the same sign language as the child. In mental health settings, it is imperative that the interpreter have specialized training in mental health, functioning effectively as a team member in the circle of care.

The following points highlight effective delivery of mental health care...

- Detailed histories should include:
 - the etiology of deafness to identify possible neurological risk factors;
 - an assessment of adequate language acquisition and the effects of delays on mental health – many d/Deaf individuals are language deprived or delayed because language may not have been accessible during the critical developmental window from birth to approximately five years of age;
 - an assessment of communication within the family and the implications on family relationships/dynamics – it is estimated that 90% of deaf children are born to hearing parents with many families never fully sharing the same language (i.e. the parents may not learn to sign fluently and the child may not master spoken English); and
 - an assessment of the lived experience of a Deaf person in terms of possible inequities, abuse and oppression.
- Appropriate assessment tools should be used. There are very few measures developed for and normed on d/Deaf individuals, so the interpretation of tests needs to be done with caution. For example, the use of heavily English language loaded items on an intelligence scale may unduly penalize the deaf child whose first language is ASL. In addition, many Deaf individuals fluent in ASL may have limited English literacy skills as it is their second language. Therefore, written surveys or test questions may be inappropriate to administer.
- The diagnosis of mental health disorders must be done with expertise. For example, the question “Are you hearing voices?” may miss the Deaf person who is psychotic but has never “heard” a voice. Autism Spectrum Disorder may also be missed or misdiagnosed given the potential for language delay in a Deaf toddler not exposed to accessible language or typical play.
- Treatment interventions need to be appropriate and accessible.

As a society, we need to recognize and affirm Deaf children and adults as representing a cultural and linguistic minority. As mental health care providers, we must also recognize that this population has different mental health risk factors requiring thoughtful, evidence-based, and specialized care.

The Centre for Deaf Education and Accessibility Forum (CDEAF) was founded in 2015 at Kings University College at Western University as a centre of research and workshop excellence regarding mental health care of Deaf people. To learn more, visit cdeaf.kingsuwo.ca or, better yet, come to one of our conferences!

For a complete list of references, please go to www.cpa.ca/psynopsis

What to Look for in Equine-Based Therapy



EFT/EAT.
Kristen Clancy Photography

Shelley Goodwin, Ph.D., Private practice and Dalhousie University; Daphne Davey, CTRBI, CanTRA EFW Committee; and Anne Barnfield, Ph.D., Brescia University College at Western and CanTRA EFW committee

Recently, there has been a lot of publicity about horses being used for therapy for individuals with a diagnosis of a mental and/or physical disorder. However, it is not as simple as going to the barn and riding a horse. There are three basic forms of equine therapy: therapeutic riding, hippotherapy, and equine facilitated wellness. Understanding what each one means can help you decide if this form of therapy is right for your client and know what to help them look for in a therapy experience.

Therapeutic Riding

Therapeutic riding (TR) provides children and adults with disabilities the opportunity to challenge themselves and achieve a sense of greater wellbeing through time spent with horses. TR is an activity offered to individuals with physical and intellectual challenges, as well as those with Autism Spectrum Disorder.¹ The focus of TR is to provide holistic therapy through teaching riding and horsemanship skills, which may result in increased mobility and other physical benefits, improvement in life skills such as communication and social functioning, and a sense of accomplishment and wellbeing.² The Canadian Therapeutic Riding Association (CanTRA) is a registered charity recognized as the national standard-setting body for TR, including instructor certification and centre accreditation. Certified instructors and trained volunteers work together with medical and/or therapy personnel to offer safe and effective programs.



Hippotherapy. Photo courtesy Les Amis de Joey

Hippotherapy

Hippotherapy, or horse therapy, is derived from “hippos,” the Ancient Greek word for horse. It uses the horse as a therapeutic “tool” rather than for horsemanship skills or goals. In a hippotherapy session, the goals and focus may be to improve a client’s functional abilities such as communication, gross or fine motor skills, or self-help skills. These improvements are then assessed using standardized measures to evaluate whether the activity and treatment are effective. Unlike TR, hippotherapy therapists must be trained and credentialed in their respective professional area (i.e., physical therapist, occupational therapist, speech-language pathologist).

Treatment exercises may include verbal commands to encourage the horse to go forward and to halt (speech therapy), clients squeezing their legs to move the horse forward (physical therapy), or the process of grooming the horse (occupational therapy). The focus is on improving the individual’s functional ability and not necessarily on personal growth or mental health issues. Treatment goals depend on the initial evaluation prepared by the therapist with the help of the rider’s medical team.

Many report that both TR and hippotherapy are fun and do not feel like therapy³ – one of the biggest benefits of such therapy, especially for children.^{4,5} There is also an increasing body of research from multiple disciplines that supports the efficacy of these forms of therapy.

Equine Facilitated Wellness

Equine-facilitated wellness (EFW) incorporates a range of counselling, education and personal development approaches, strategies and techniques that bring humans and equines together in healing and learning environments. Terms currently used in this area of practice include: equine-facilitated counselling, equine experiential learning, equine-assisted/facilitated psychotherapy, and equine-assisted personal development.

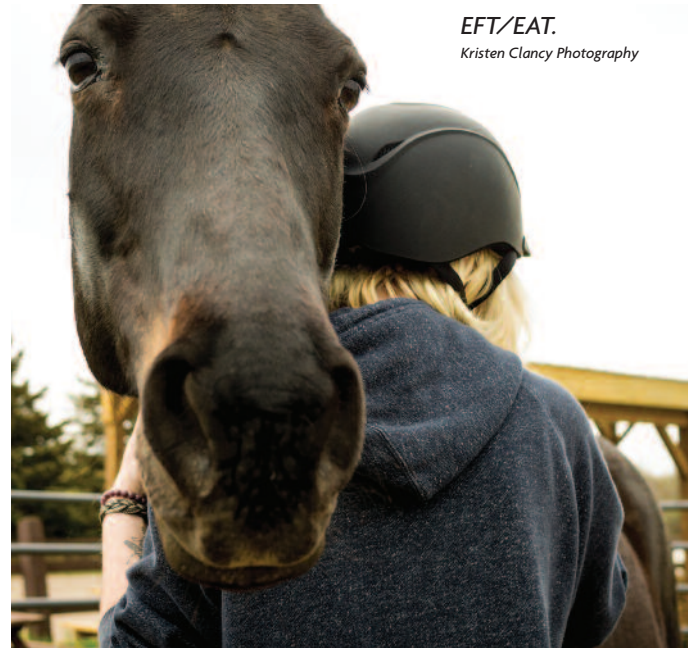
EFW includes a variety of activities with horses, such as grooming, longeing (technique for training horses), riding and driving. In this type of therapy the horse is not a “tool” but a partner in the therapy process and is treated with great respect.

Using horses in mental health therapy is a much newer type of therapy, and guidelines and policies for EFW are not as well developed as those for the other two forms of equine therapy. If your client is considering this wellness practice for mental health concerns, consider that CanTRA’s best practice is to have a credentialed mental health professional (e.g., social worker, psychologist) or education professional and a certified equine professional working together to provide therapy to the client.*

Once a thorough assessment is completed in EFW therapy, treatment goals are developed with the client and may

EFT/EAT.

Kristen Clancy Photography



include self-esteem and self-help issues, boundary awareness and other personal growth and development concerns. The environment is carefully supervised and the process is professionally facilitated so that interactions occur with specially selected, trained equine partners.

While there are an increasing number of empirical studies showing that the blending of therapeutic activities with animals is helpful,^{6,7} as yet, there is no strong evidence-based research that supports EFW for mental health disorders. Researchers are, however, beginning to explore this new approach to mental health care⁸ – studies are currently underway to evaluate the effectiveness of EFW therapy for depression, anxiety and post-traumatic stress disorder.

If your client decides to give EFW a try, it is strongly recommended that they follow the standards set by CanTRA. The organization suggests a team approach is best and that the team should include a certified mental health professional (e.g., psychologist, social worker) or education professional, horses that are specifically chosen for their suitability to do this kind of work, and a certified equine professional. It may also be helpful to ask others who have tried the specific therapy being considered about their experience. Because of the nature of working with animals, CanTRA advocates for proper professional supervision and that only one client and one horse be together in the arena at a time.

When implemented appropriately, these various forms of equine-based therapy can be a novel way to experience self-growth and healing. Anyone interested in learning more about equine therapies is encouraged to consult www.cantra.ca and www.equinefacilitatedwellness.org.

*<https://cantra.ca/en/our-services/equine-facilitated-wellness>

Pain Disability

The Importance of Psychosocial Prevention and Intervention



Kenneth D. Craig, O.C., Ph.D., University of British Columbia

Ongoing pain can be devastating and debilitating. Large numbers of people, around 20% of the Canadian population, have pain that persists or has recurred after healing would be expected and that is of sufficient severity to warrant health care professional consultation. That is approximately 7 million Canadians with chronic pain! Prevalence is greater among vulnerable populations (e.g., infants and children; persons who are older; and people with cognitive impairment, mental health problems, or dementias). Beyond personal suffering and pain, these

people endure difficulties in their ability to maintain quality of life, work, enjoy families and friends, and participate in the community. They also make substantial and expensive demands on the health care system. Fortunately, psychologists can make a big difference.

Everyday life experience with the inevitable cuts, bruises, sprains, medical procedures and the like, from infancy through to the later years, provides most people with a limited understanding of pain. It is commonly perceived as sensations arising from tissue damage caused by injury or disease. The popular conception is of immediate rapid onset of distress that is to be endured for

somewhat short spans of time, maybe only seconds or less likely weeks, as people take care of themselves and healing sets in. If the pain is severe or persistent, people sensibly seek medical advice. Indeed, pain provides the prime reason for consulting a physician. This limited biomedical model leads most people to believe medical interventions that address injury or disease or palliate pain are the effective approach to pain relief. As a result, the emphasis of our provincial health care systems is on acute care of this type.

If only it were so simple! If this model worked universally, we would not have the large number of people suffering chronic pain disabilities described above. The reality is pain often doesn't go away – acute pain, which is often poorly managed, becomes chronic more often than one would hope. The very best medical assessments with the finest technology available frequently cannot adduce evidence of tissue damage. As well, medical interventions ranging from pharmaceuticals to surgery, bodily manipulations, and other approaches fail to provide lasting relief for a large number of people. In consequence, psychological distress and social problems, often concurrent and contributory factors to begin with, become increasingly important. Yet, most health care professionals are inadequately trained to understand pain or to be able to extend the care they provide beyond biomedical interventions. Over- and under-prescription of drugs and increasingly demanding medical regulatory systems are one of the consequences.

What remains to be done after the failure of narrow-minded biologically-oriented research and practice to provide relief from pain and related disability? The pain remains an overwhelmingly salient life reality for patients. They must continue to struggle with even the basic necessities of life – eating, sleeping, dressing, ambulation, self-care or toileting – let alone the demands of engaging with others, visiting, talking, and participating in activities. Small wonder that work, domestic responsibilities, and active engagement with employers, family and friends, what we refer to as living, can be achieved only at excruciating costs. The friction of these aggravations, some niggling, others major, often provokes self-doubt, anxiety and fear, mood changes, isolation, perceived injustice, conflict with others, and inactivity with accompanying loss of fitness. They are also likely to suffer social stigma, rejection by others who cannot understand why the pain persists, given dominance of the acute biomedical pain

model, and patients often encounter disbelief, discrimination, and social rejection.¹

Can psychologists provide solutions? The overwhelming majority of people suffering from pain will benefit if available knowledge were applied uniformly and if they had access to appropriate care. Failure to address the 'psychosocial' as soon as possible is often the culprit. The psychologist's toolkit includes cost-effective, evidence-based interventions for addressing, anxiety, fear-avoidance, depression, anger, perceived injustice, catastrophizing, functional impairment, etc. Screening for problems of this type is often the key to early intervention. Evidence-based therapies within the cognitive/behavioural therapy tradition are used extensively in the few multidisciplinary clinics that exist to good effect. These draw upon basic psychological science relating to stress, relaxation, expectancies, decision making, cognitive development and the like. Lynch et al. describe clinical management of chronic pain using the broad biopsychosocial model.²

Social modulation of pain is often neglected and must also command attention.^{3,4} Social factors determine whether people are exposed to pain, how pain is perceived and communicated to others, and how professionals and others appraise and react to the person's distress. Interpersonal therapies, family systems therapies, and contextual approaches that consider relationships and patient engagement all reflect recognition of the complex social systems that provide care or fail to do so. Simply validating patient experiences and providing adequate explanation within the biopsychosocial context can be very powerful.

Regrettably, considerable pain is not recognized by others, pain assessment often falls short of satisfactory, and pain management frequently is ineffective or inappropriate. We have proposed updating the definition of pain to better address psychosocial issues: "Pain is a distressing experience associated with actual or potential tissue damage with sensory, emotional, cognitive, and social components."⁵ This revised definition provides focus upon those features of experience, emotional, cognitive, and social that the psychological toolkit is well prepared to handle. Ultimately, access to psychosocial management of long-term pain disabilities depends upon reconfiguring agencies, hospitals, and health care systems—there are some glimmerings of hope.

For a complete list of references, please go to www.cpa.ca/psychopsis

The overwhelming majority of people suffering from pain will benefit if available knowledge were applied uniformly and if they had access to appropriate care.

The Psychology of Pain-Related Disability



Michael Sullivan, Ph.D., McGill University

In North America, work-related musculoskeletal conditions are the most expensive non-malignant health condition affecting the working-age population.¹ Musculoskeletal disorders can arise from activities or incidents involving muscular strain, falls, repetitive movements or physical impact. Although the majority of musculoskeletal conditions recover within weeks of injury, a significant proportion of individuals will remain permanently disabled. The prevalence of work disability associated with musculoskeletal conditions has been increasing steadily in spite of the launch of numerous policy, prevention and intervention initiatives.

By the mid-1960s, mounting clinical and scientific evidence suggested traditional medical approaches to understanding (and treating) pain-related disability were inadequate. Research was accumulating, indicating that medical status variables alone could not fully account for presenting symptoms of pain and disability arising

consequent to injury.^{1,2} Biopsychosocial models have since been slowly replacing traditional medical models as the dominant conceptual frameworks guiding research and practice on pain-related disability. These models suggest that a complete understanding of pain experience and pain-related disability consequent to injury require consideration of physical, psychological and social factors.^{3,4}

As intuitive as the premise might be, pain severity is not the primary determinant of prolonged work disability following injury. Overwhelmingly, research suggests that pain severity accounts for only about 10% of the variance in the disability associated with musculoskeletal conditions.⁵ Still, pain reduction remains the major focus of interventions offered to individuals who have sustained musculoskeletal injuries. In light of the weak relation between pain and disability, it is perhaps not surprising that pain-focused interventions have not been shown to be effective in reducing the magnitude or duration of work-disability. Indeed, certain pain-focused interventions, such as the prescription of opiates, have been shown to increase rather than decrease disability.⁶

Our work over the past two decades has examined the role of pain-related psychosocial factors as determinants of work-disability following musculoskeletal injury. Numerous investigations have shown that individuals who engage in catastrophic or alarmist thinking about their symptoms, and who feel that they are suffering unjustly, are at high risk for prolonged disability following musculoskeletal injury.^{7,8} The predictive value of catastrophizing and perceived injustice for prolonged work-disability has been so robust that these psychosocial variables have risen to the status of 'risk factors' for problematic recovery.¹

Over the past two decades, great strides have been made in alerting clinicians to the importance of assessing psychosocial risk factors in their evaluations of individuals suffering from debilitating pain conditions. Measures of pain-related psychosocial risk, such as the Pain Catastrophizing Scale (PCS)⁸ and the Injustice Experiences Questionnaire (IEQ)⁷ have been incorporated into the assessment protocols of pain clinics and rehabilitation centers around the world.

Although psychosocial risk measures such as the PCS and the IEQ have been readily adopted, the clinical community has lagged in the development and implementation of interventions specifically designed to target these psychosocial risk factors. While speaking at a recent rehabilitation conference, I asked members of an audience of approximately 1,000 clinicians to raise their hand if they used a measure of pain catastrophizing as part of their assessment protocol. Nearly every hand in the audience was raised. I then asked what clinicians did differently when one of their clients obtained a high score on the measure of catastrophizing. Not one hand was raised to offer a response.

The assessment of psychosocial risk factors is only worthwhile if there are plans to institute an intervention specifically designed to target psychosocial risk factors. Unfortunately, in many settings, the assessment of pain catastrophizing and perceived injustice (and other psychosocial risk factors) is more likely to be used to blame the client for failing to respond to treatment, as opposed to being used to tailor treatment to the client's needs.

When measures of psychosocial risk are used only for assessment purposes, as opposed to treatment planning, their use can actually be harmful to the client. I have witnessed many occasions where psychosocial risk measures were included as part of a functional capacity evaluation. When results fail to reveal a consistent picture of physical limitations, and the patient obtains high scores on pain-related psychosocial risk factors, the conclusion is drawn that the patient's problem is psychological as opposed to physical. This erroneous conclusion can have disastrous consequences for the client's eligibility for compensation.

Can the current situation be improved? One significant challenge is that primary care services are not well suited for targeting psychosocial risk factors in the early stages of recovery. Primary care practitioners, such as physicians and physical therapists, have neither the time nor the skill set necessary to effectively manage psychosocial risk factors for work-disability. Additionally, there are indications that primary care practitioners do not necessarily consider their role to include involvement in the return-to-work process.⁹

It is unrealistic to propose that referral for psychological services should be considered earlier in the recovery process following injury. While, psychological services are an important component of the management of chronic pain, psychological services are under-represented in the management of acute injury. Perhaps, based more on experience than empirical data, many injury insurers are weary that an early referral to a psychologist will prolong rather than decrease the period of work-disability. Indeed, the majority of clinical psychologists are ill-equipped to function as 'return-to-work' interventionists. The processes of work-disability and pathways to occupational re-integration are not core elements in the curricula of clinical training programs in psychology.

Our recent work suggests that, unless successful return to work is the outcome of rehabilitation interventions for musculoskeletal pain, the majority of treatment gains are lost shortly following termination of treatment.¹⁰ From this perspective, neglecting to place return-to-work as a central objective in the treatment of musculoskeletal injury could be associated with high costs. However, the issue is more than simply economic. Return-to-work represents the highest level of independence that can be offered to a work-disabled individual with a musculoskeletal condition. Our clients are unlikely to realise this outcome, unless we are prepared to make return to work part of our treatment plan.¹¹

Future research is likely to continue to reveal that psychological processes are critical determinants of recovery trajectories following injury. The accumulating evidence base will call for the incorporation of psychological services earlier in the management of disabling injury. However, for psychologists to effectively respond to these calls, important changes will need to take place. More research will need to focus on psychological determinants of prolonged work-disability and the outcome of this research will need to provide the empirical foundation for the development of new approaches to intervention. Our clinical programs will need to incorporate training on the psychological management of work-disability, and psychologists will need to consider placing return to work as a central objective of the treatments they offer to work-disabled clients.

For a complete list of references, please go to www.cpa.ca/psynopsis

From the President's Desk

*Patrick Baillie, Ph.D., LL.B.,
President, Canadian Psychological Association*

The Canadian Psychological Association Association

(CPA) is alive and well – and I sincerely hope that I won't do anything to change that during my term as President of the CPA in 2017-2018.

As I said in my brief comments at the Annual General Meeting in Toronto in June 2017, I expect any changes made as a result of initiatives commenced during my term as President to be more evolutionary than revolutionary. The Association is in good fiscal shape, has an important presence with the federal government, with our provincial partners, and with a host of national organizations, and benefits from the skills of our current CEO and staff. I don't see a need for any overhaul.

What I would like to see, though, are steps made that strengthen the three pillars of the CPA, namely: practice, education, and science. I would like to continue movement towards making the doctoral degree the standard across Canada for entry into the practice of professional psychology; I would like to initiate a small project to help undergraduate students understand the long-term value of seeking out an accredited graduate training program; and I would like to better share psychological science with government and stakeholders to ensure policies best

assist our neighbours, colleagues, families, and friends.

Quite simply, thanks to the considerable efforts of our members and others in our field, we have so much good science that can be shared with the public, with government, and with industry. For example, we have information that can help parents and medical practitioners better manage pain in children from experts such as Dr. Melanie Noel and Dr. Christine Chambers; information on how social determinants of health may impact criminal behaviour that can help governments move beyond ministerial silos that sometimes cut off housing and employment supports from direct health services thanks to new research by scientists like Dr. Slawomir Olszewski; and information to assist employers in providing safe and productive workplaces from researchers like our former President, Dr. Kevin Kelloway. There are many ways that we can give back to the profession of psychology, all the while assisting others. I hope to continue to highlight quality research during my term as President and in my address at the CPA's 2018 National Convention.

Certainly, a highlight of the coming year will be our convention, which is being merged with the International Congress of Applied Psychology for a larger, international event in Montreal, Quebec from June 26-30, 2018. This not-to-be-missed five-day congress will



bring together an impressive array of speakers. The CPA's Board has taken steps to assist in reducing the cost of attending, providing an additional subsidy for those CPA members who register early, so I hope that we will see you there.

The CPA will, I trust, continue to be a member-driven organization, responsive to those issues being raised by our nearly 7,000 members who are academics, researchers, practitioners, students, and interested partners. The Board has approved some initial steps towards restructuring, moving toward enhancing the input from members by potentially having more directly elected seats. Beyond that formal mechanism of collaboration, I ask that you please contact me if you have any particular concerns or suggestions.

Thank you for the opportunity to serve as your President during the 2017-2018 term.



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Le mot du président

*Patrick Baillie, Ph. D., LL.B.,
président, Société canadienne de psychologie*

La Société canadienne de psychologie (SCP) se porte très bien – et j’espère sincèrement ne rien faire qui puisse changer cela pendant mandat de président de la SCP en 2017-2018.

Comme je l’ai dit dans la brève allocution que j’ai faite à l’assemblée générale annuelle, qui s’est tenue à Toronto, en juin 2017, les changements qui découleront des initiatives amorcées pendant mon mandat seront plus graduels que révolutionnaires. L’association est en bonne santé financière; elle a une forte présence auprès du gouvernement fédéral et d’une foule d’organisations nationales, et elle bénéficie des compétences de la chef de la direction et du personnel. À mon avis, ce sont des acquis et aucune transformation en profondeur n’est nécessaire.

Cependant, ce que j’aimerais voir progresser, ce sont les initiatives que nous menons pour renforcer les trois piliers de la SCP que sont la science, la formation et la pratique. J’aimerais continuer le mouvement amorcé pour faire du doctorat la norme canadienne régissant le droit d’exercer la profession de psychologue; j’aimerais lancer un petit projet afin d’amener les étudiants de premier cycle à saisir la valeur à long terme des stages et des internats offerts par un programme de formation agréé; j’aimerais, enfin, en faire davantage pour partager les résultats de la recherche en psychologie avec le gouvernement et les intervenants afin que les politiques aident véritablement nos voisins, nos collègues, notre famille et nos amis.

En somme, grâce aux efforts considérables de nos membres et d’autres personnes du milieu de la psychologie, nous avons acquis des connaissances scientifiques extrêmement poussées, dont le public, le gouvernement et l’industrie peuvent profiter. Par exemple, grâce à des experts comme les D^{res} Melanie Noel et Christine Chambers, les psychologues mettent à la disposition des parents et des médecins de l’information susceptible d’aider à mieux

comprendre la gestion de la douleur chez les enfants; grâce au travail novateur de chercheurs comme le D^r Slawomir Olszewski, les psychologues montrent comment les déterminants sociaux de la santé peuvent influencer le comportement criminel, et leur savoir pourrait aider les gouvernements à dépasser le cloisonnement ministériel qui, parfois, sépare l’aide au logement et l’aide à l’emploi des services de santé directs. Nous pouvons, de multiples façons, redonner à la profession de psychologue, tout en aidant les gens. Tout au long de mon mandat de président et dans l’allocution que je prononcerai au congrès national de la SCP de 2018, j’ai l’intention de continuer à mettre en valeur les recherches de qualité menées par les psychologues.

Un des moments forts de l’année sera, sans aucun doute, notre congrès, qui se tient conjointement avec l’International Congress of Applied Psychology. Le congrès, qui aura lieu à Montréal, au Québec, du 26 au 30 juin 2018, sera un événement international d’envergure. Pendant cinq jours, un éventail impressionnant de conférenciers partagera son savoir. C’est un événement à ne pas manquer. Le conseil d’administration de la SCP a pris des mesures pour réduire le coût de participation au congrès en offrant une subvention supplémentaire aux membres de la SCP qui s’inscrivent tôt. J’espère que vous y serez.

Je suis persuadé que la SCP restera une organisation dirigée par ses membres et à l’écoute des questions soulevées par nos quelque 7 000 membres, constitués d’universitaires, de chercheurs, de praticiens, d’étudiants et de partenaires intéressés. Le conseil d’administration a approuvé certaines mesures initiales dans l’optique d’une restructuration à venir, qui vise à améliorer la participation des membres en réservant, possiblement, un plus grand nombre de sièges à pourvoir au scrutin direct. En plus de ce mécanisme officiel de collaboration, je vous invite à me faire part de vos préoccupations ou de vos suggestions.

Je vous remercie de me donner la chance d’occuper la fonction de président de la SCP en 2017-2018.



JUNE 26-30
29th International Congress
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CPA HIGHLIGHTS



*Karen R. Cohen, Ph.D., C. Psych, Chief Executive Officer and
Lisa Votta-Bleeker, Ph.D., Deputy CEO and Director, Science Directorate*

Below is a list of our top activities since the last issue of *Psynopsis*. Be sure to contact membership@cpa.ca to sign up for our monthly CPA News e-newsletter to stay abreast of all the things we are doing for you!

1 Annual Report

On June 9, the CPA presented its annual report at the Annual General Meeting for members. The report covers the period of June 2016 to May 2017. Members who wish to review the report can find it online.

http://cpa.ca/docs/File/Governance/2017Annualreport_ENG_FINAL.pdf

2 First Street Accord

On August 4, Dr. Patrick Baillie, President, CPA; Dr. Karen Cohen, CEO, CPA; Dr. Anthony Puente, President, APA; and Dr. Arthur Evans, CEO, APA re-signed the First Street Accord at the APA's 2017 National Convention in Washington, D.C. The accord mutually recognizes the accreditation activities each association undertakes in its own country. It also allows for mutual monitoring and information exchange related to psychology education accreditation in North America.

<http://www.cpa.ca/accreditation/accreditationthroughoutnorthamerica>

3 Recommendations on Cannabis

The CPA's task force charged with making recommendations on the legalization of cannabis has presented its report to the board of directors for approval. The next issue of *Psynopsis* will feature these recommendations along with current research and best practices related to the effects of cannabis use and cannabis addiction treatment.

4 Canadian Journal of Experimental Psychology – Special Issue

The *Canadian Journal of Experimental Psychology* has produced a two part special issue on everyday attention. All articles from both Part I (June) and Part II (September) are available online, and the introduction is open access. The issue includes a number of topical papers, including: "The Smartphone and the Driver's Cognitive Workload: A Comparison of Apple, Google, and Microsoft's Intelligent Personal Assistants" and "Chatting in the Face of the Eyewitness: The Impact of Extraneous Cell-Phone Conversation on Memory for a Perpetrator."

<http://psycnet.apa.org/PsycARTICLES/journal/cep>

5 CTV Your Morning

On August 18, Dr. Karen Cohen appeared on CTV's Your Morning to discuss the need for more publicly funded psychotherapy in Canada with host Anne-Marie Mediwake and psychiatrist Dr. Alain Lesage.

<http://www.ctv.ca/YourMorning/Video/Could-Britains-revolutionary-free-therapy-program-work-in-Canada-vid1189119>

6 Indigenous Task Force Conference

The CPA's Indigenous Task Force held a conference at the Native Canadian Centre of Toronto from August 18-21. The event brought together task force members; Indigenous elders, scholars, front line service providers, and administrators; allies from the profession of psychology; and Aboriginal Psychology Section members to discuss assessment, research, education, and program evaluation of therapies for Indigenous peoples. The task force will be preparing a series of recommendations and guidelines for culturally appropriate approaches when working with First Nations, Inuit, and Métis peoples. The conference was supported by the University of Guelph-Humber.

7 New Board Members

On June 9, the following seven members took on new roles with the CPA's board of directors:

- Dr. Patrick Baillie, President
- Dr. Sam Mikail, President-Elect
- Ms. Carmen Bellows, practitioner
- Ms. Chelsea Moran, student representative
- Dr. Kerri Ritchie, CCPPP representative
- Dr. Jo-Anne LeFevre, CSBBCS representative
- Dr. Andrea Piotrowski, CPAP representative (appointed by the Board for a one year term)

The CPA would like to thank outgoing board members for their commitment and service:

- Dr. E. Kevin Kelloway (Past-President),
- Ms. Zarina Giannone (student representative),
- Dr. Rupal Bonli (CCPPP representative), and
- Dr. Jean Saint-Aubin (CSBBCS representative)

The full list of the CPA's board of directors can be found on page 3 of this issue.

8 Subsidized ICAP 2018 Registration Fees for Members

The CPA will subsidize the participation of all members and student affiliates in ICAP 2018. CPA members who register before the early bird deadline will automatically be given an additional discount of \$100 off the \$595 early bird registration fee. CPA student affiliates will receive a \$75 reduction in student congress registration fees regardless of when they register. To learn more about the upcoming congress, visit the ICAP 2018 website and sign up for the congress e-newsletter.

<http://www.icap2018.com/>

9 New York Times

Earlier this year, Dr. Karen Cohen was interviewed by journalist Benedict Carey for a piece on the U.K.'s Improving Access to Psychological Therapies program. The article appeared in the New York Times on July 24 and was reprinted in other publications, including the Globe and Mail on August 3.

<https://www.nytimes.com/2017/07/24/health/england-mental-health-treatment-therapy.html?smid=fb-nytimes&smtyp=cur>

10 New Task Forces

The CPA recently struck two new task forces. The progress monitoring task force will develop recommendations for monitoring outcomes in psychotherapy, and the opioid task force will develop recommendations for best tackling the current opioid crisis in Canada.

FAITS SAILLANTS

des activités de la SCP



Karen Cohen, Ph. D., C. Psych., chef de la direction, et
D^{re} Lisa Votta-Bleeker, Ph. D., directrice générale associée et directrice de la Direction générale de la science

Voici la liste des principales activités menées depuis la publication du dernier numéro de *Psynopsis*.
Écrivez à membership@cpa.ca pour vous abonner à notre bulletin électronique semestriel, *Nouvelles de la SCP*,
pour vous tenir au courant de toutes les choses que nous accomplissons pour vous!

1 Rapport annuel

Le 9 juin, la SCP a présenté aux membres son rapport annuel lors de l'assemblée générale annuelle. Le rapport couvre la période de juin 2016 à mai 2017. Les membres qui souhaitent examiner le rapport peuvent consulter celui-ci en ligne.

http://www.cpa.ca/docs/File/Governance/2017AnnualReport_FR_FINAL.pdf

2 First Street Accord

Le 4 août, le D^r Patrick Baillie, président de la SCP, la D^{re} Karen Cohen, chef de la direction de la SCP, le D^r Anthony Puente, président de l'APA, et le D^r Arthur Evans, chef de la direction de l'APA, ont signé de nouveau le First Street Accord lors du congrès national de l'APA de 2017, qui s'est tenu à Washington, D.C. L'accord est une déclaration de reconnaissance mutuelle, qui reconnaît les activités liées à l'agrément que mène chaque association dans son pays respectif. Il permet également la surveillance mutuelle et l'échange d'informations relatives à l'agrément des programmes de formation en psychologie en Amérique du Nord.

<http://www.cpa.ca/agreement/agreementameriquedunord>

3 Recommandations sur le cannabis

Le groupe de travail de la SCP chargé de faire des recommandations relativement à la légalisation du cannabis a présenté son rapport au conseil d'administration aux fins d'approbation. Le prochain numéro de *Psynopsis* présentera ces recommandations, ainsi que la recherche en cours sur les répercussions de l'usage du cannabis et sur le traitement de la dépendance au cannabis, et les pratiques exemplaires en la matière.

4 Numéro spécial de la Revue canadienne de psychologie expérimentale

La *Revue canadienne de psychologie expérimentale* a produit un numéro spécial en deux parties sur l'attention au quotidien. Tous les articles de la partie I (juin) et de la partie II (septembre) sont disponibles en ligne, et l'introduction est offerte en libre accès. Le numéro propose des articles thématiques, dont : « The Smartphone and the Driver's Cognitive Workload: A Comparison of Apple, Google, and Microsoft's Intelligent Personal Assistants » et « Chatting in the Face of the Eyewitness: The Impact of Extraneous Cell-Phone Conversation on Memory for a Perpetrator ».

<http://psycnet.apa.org/PsycARTICLES/journal/cep>

5 « Your Morning » sur le réseau CTV

Le 18 août, la D^{re} Karen Cohen est apparue sur les ondes de CTV, à l'émission « Your Morning », afin de faire valoir l'intérêt des psychothérapies financées par l'État et les besoins à ce chapitre au Canada, avec l'animatrice Anne-Marie Mediwake et le psychiatre Alain Lesage.

<http://www.ctv.ca/YourMorning/Video/Could-Britains-revolutionary-free-therapy-program-work-in-Canada-vid1189119>

6 Conférence du groupe de travail sur la psychologie des autochtones

Le groupe de travail de la SCP sur la psychologie des autochtones a tenu une conférence au Native Canadian Centre of Toronto du 18 au 21 août. L'événement a réuni les membres du groupe de travail, des aînés autochtones, des universitaires, des fournisseurs de services de première ligne et des administrateurs, des alliés de la profession de psychologue et des membres de la Section de la psychologie des autochtones, qui étaient tous là pour discuter de l'évaluation, de la recherche, de l'éducation et de l'évaluation de programme des thérapies offertes aux populations autochtones. Le groupe de travail préparera une série de recommandations et de lignes directrices, qui aideront à concevoir une approche culturellement adaptée à l'intervention auprès des membres des Premières Nations, des Inuits et des Métis. La conférence était financée par l'Université de Guelph-Humber.

7 Nouveaux membres du conseil d'administration

Les personnes suivantes ont assumé de nouveau rôle avec le conseil d'administration de la SCP le 9 juin :

- D^r Patrick Baillie, président
- D^r Sam Mikail, président désigné
- Mme Carmen Bellows, administratrice représentant les praticiens
- Mme Chelsea Moran, représentante des étudiants
- D^{re} Kerri Ritchie, représentante du CCPPP
- D^{re} Jo-Anne LeFevre, représentante de la SCCCSC
- D^{re} Andrea Piotrowski, représentante du CSPP (nommée par le conseil d'administration pour un mandat d'un an)

Merci aux membres sortants pour leur dévouement et leur travail:

- le D^r E. Kevin Kelloway (président sortant),
- Mme Zarina Giannone (représentante des étudiants),
- le D^r Rupal Bonli (représentant du CCPPP) et le
- D^r Jean Saint-Aubin (représentant de la SCCCSC)

8 Subvention des frais d'inscription à l'ICAP 2018 pour les membres

La SCP subventionnera la participation de tous les membres et membres étudiants à l'ICAP 2018. Les membres de la SCP qui s'inscrivent avant la date limite de préinscription recevront automatiquement un rabais supplémentaire de 100 \$ sur le tarif de préinscription de 595 \$. Les membres étudiants de la SCP recevront une réduction de 75 \$ sur les frais d'inscription au tarif étudiant, peu importe le moment où ils s'inscrivent. Pour en savoir plus sur le congrès, veuillez visiter le site Web de l'ICAP 2018 et inscrivez-vous au bulletin électronique du congrès.

<http://www.icap2018.com/>

9 New York Times

Plus tôt cette année, la D^{re} Karen Cohen a été interviewée par le journaliste Benedict Carey dans le cadre d'un article sur le programme Improved Access to Psychological Therapies (IAPT) du Royaume-Uni. L'article est paru dans le *New York Times* le 24 juillet et a été reproduit dans d'autres publications, y compris le *Globe and Mail*, le 3 août.

<https://www.nytimes.com/2017/07/24/health/england-mental-health-treatment-therapy.html?smid=fb-nytimes&smtyp=cur>

10 Nouveaux groupes de travail

La SCP a créé récemment deux nouveaux groupes de travail. Le groupe de travail sur le suivi de l'évolution du traitement sera chargé d'élaborer des recommandations sur le suivi des résultats de la psychothérapie, et le groupe de travail sur les opioïdes élaborera des recommandations visant à aborder la crise actuelle des opiacés au Canada.



Days
Jours
3



Attendees
Participants
1,560



Meeting Rooms
Salles de réunion
19



Continuing Education
Workshops
Ateliers d'éducation
permanente
31





Sessions
Séances
130



GIMME-5 Presentations
Présentations GIMME-5

163



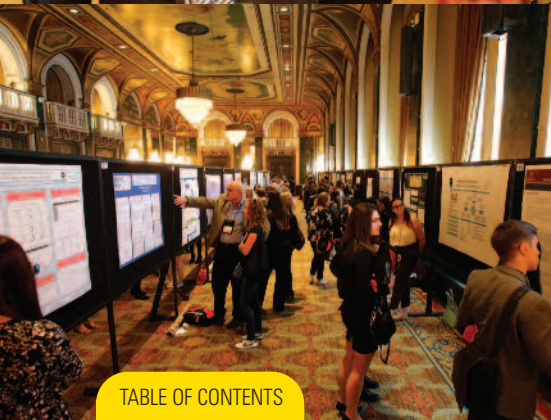
Exhibitors
Exposants

23



Section and
Committee Meetings
Réunions des
sections et comités

41



Posters
Affiches

772



2017 CPA Award Recipients and Fellows

Les récipiendaires des prix et fellows de la SCP 2017

Gold Medal for Distinguished Lifetime Contributions to Canadian Psychology

Prix de la médaille d'or pour contributions remarquables à la psychologie canadienne au cours de l'ensemble de sa carrière

David Zuroff, Ph.D.



John C. Service Member of the Year Award

Prix John Service pour le membre de l'année

Keith Wilson, Ph.D.

Donald O. Hebb Award for Distinguished Contributions to Psychology as a Science

Prix Donald O. Hebb pour contributions remarquables à la psychologie en tant que science

Michel Dugas, Ph.D.



Award for Distinguished Contributions to Education and Training in Psychology in Canada

Prix pour contributions remarquables à l'éducation et à la formation en psychologie au Canada

Patricia Rowe, Ph.D.



Humanitarian Award / Prix pour réalisation humanitaire

Louise Bradley



Award for Distinguished Contributions to the International Advancement of Psychology

Prix pour contributions remarquables à l'avancement international de la psychologie

Keith Dobson, Ph.D.



Award for Distinguished Contributions to Public or Community Service

Prix pour contributions remarquables au service public ou communautaire

Gira Bhatt, Ph.D.



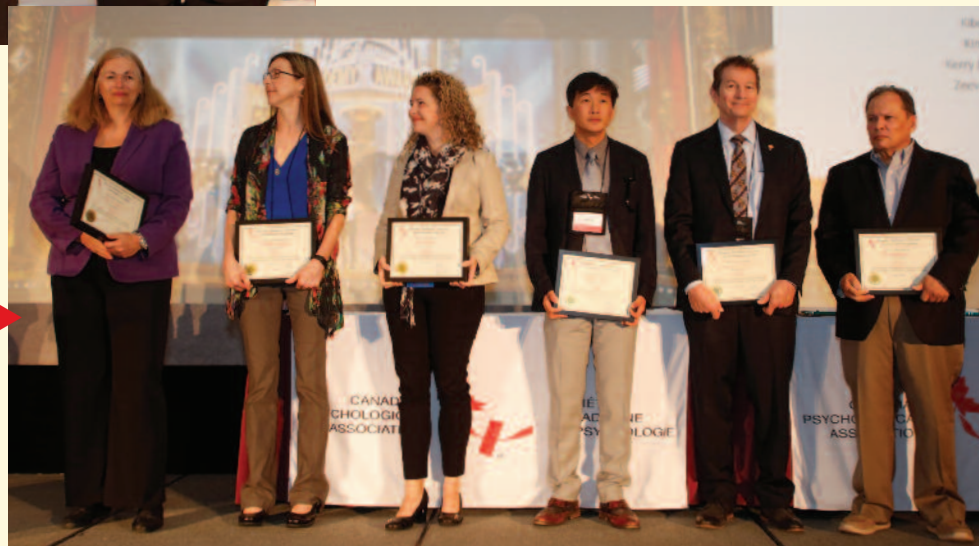
President's New Researcher Awards

Prix du nouveau chercheur décerné par le président

Marina Milyasvskaya, Ph.D.

Lauren Walker, Ph.D.

Sheila N. Garland, Ph.D., R.Psych.
(award accepted on her behalf)



Elected Fellows
Fellows élus

Nancy M. Arthur, Ph.D.

D. Ramona Bobocel, Ph.D.

Kibeom Lee, Ph.D.

Kim Lavoie, Ph.D.

Kerry J. Mothersill, Ph.D.

Zeev Rosberger, Ph.D.

Research in a Celtic Nation



Maxine Crawford - Psychology doctoral student, University of British Columbia (Submitted by the International Relations Committee.)

As a graduate student, I always dreamed of doing research overseas, so when I stumbled across the European Centre for Environment and Human Health (ECEHH) in Cornwall, England, my desire started to coalesce into a plan. I came across research by the ECEHH while conducting a literature search for my Ph.D. thesis, and I immediately recognized they had an amazing team of academics and researchers I wanted to work with.

As part of the University of Exeter Medical School's research program, the ECEHH explores the complexity of environment and human health issues in an interdisciplinary fashion. The ECEHH team uses science, the arts, and the humanities to improve their understanding of the opportunities and health risks presented by the environment. Collaborations with business, government, and the not-for-profit sector are at the heart of the ECEHH's work.

Sending an introductory email and arranging Skype meetings were the easy part of this undertaking. Getting organized to go overseas for four months with my family and my dog was much more complicated. My advice is to start early on in the process and keep lists with associated timelines.

When planning a research trip like mine there are anticipated hurdles such as ethics applications, paperwork, and finding lab space, but it is the unanticipated hurdles that are most challenging. Something I hadn't accounted for is that many UK apartments have a minimum six-month lease and they want you to have a UK bank account. It was challenging for us to find accommodation given our shorter stay (and the dog!). But by thinking outside of the box and approaching short-term rentals during the low holiday season we were able to secure accommodation for four months.

Regarding the work environment logistics, I was fortunate that my supervisor arranged many of the office details before I arrived, which was incredibly helpful. Anyone who has started a new job knows how many permissions, forms, etc. need to be completed, and having some of this done before you arrive can save a lot of time.

The formal research team consisted of my supervisor, two research assistants, and me, but we also had a lot of assistance from other ECEHH staff. We recruited community members through social media and posters to complete a two-part study examining their emotional response to natural and urban settings. Participants completed the first part of the study online, and came to the ECEHH for part two. The study asked participants to rate their emotional forecasts to natural and urban environments in part one, and to provide real-time assessments to videos of nature and urban settings in part two.

Celtic Nation

The research project was a valuable experience, but I think the collaborations and networking at the ECEHH were just as rewarding. I had never worked in such an interdisciplinary environment before, and I found the conversations and dialogue thought provoking and challenging.

I think interdisciplinary collaboration is the future of research and many funding bodies believe this as well. Interdisciplinary teams can view a problem through multiple lenses and find their way to a more nuanced solution. Of course there are challenges finding a common language and methodology, but I believe you end up with a superior outcome.

If you too aspire to conduct research overseas, I encourage you to pursue it. In my experience, researchers are open to collaboration and are very supportive of early scholars and the rewards are richer and more diverse than you could ever imagine.

For a complete list of references, please go to www.cpa.ca/psynopsis

2017 Robert Sommer Award for Best Student Paper in Environmental Psychology

The Environmental Psychology Section is pleased to announce that Ms. Caroline MacKay received the 2017 Robert Sommer Award for best student paper in environmental psychology for her paper, *The impact of pro-environmental classroom norms in environmental education*. The award, commemorating the significant impact of Dr. Robert Sommer's research on the emerging field of environmental psychology in the 1950s, is accompanied by a \$150 prize. Ms. MacKay is a graduate student in the Department of Psychology at Simon Fraser University and is supervised by Dr. Michael Schmitt.



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Ethical Challenges and Guidance

for Supervisors in Psychology Regarding Letters of Reference for Students and Trainees

Kathryn A. Birnie, Ph.D., C.Psych (Supervised Practice), Post-doctoral Fellow, University of Toronto and The Hospital for Sick Children, and former student member, CPA Committee on Ethics

Part of any supervisor's role in the profession of psychology is writing letters of reference on behalf of students seeking graduate school admission, internships or postdoctoral fellowships. Admission boards rely heavily on reference letters when evaluating candidates so, if negative, these letters can have a great impact on future opportunities for students.^{1,2,3} Unlike letters of recommendation (e.g., for an award or scholarship), letters of reference are intended and/or perceived to be assessments of character and competence and are used for gatekeeping in the profession.

Challenges

Psychology professionals have long experienced challenges and frustrations with writing letters of reference. Commentaries in *American Psychologist* in the 1960s called for the development of standardized forms to increase efficiency in completing reference letters.⁴ They also highlighted that issues of positive bias resulting from students' selection of referees may reduce the usefulness of letters to decision-makers.⁵

A long recognized problem is that the majority of reference letters are entirely positive, and therefore uninformative.² Supervisors and training directors estimate leniency bias (i.e.,

more positive than warranted) in reference letters for psychology interns at 45-53%, followed by central tendency bias (i.e., more average than warranted) at 32-40%, with a minority estimate of strictness bias (i.e., more negative than warranted) at 6-9%.⁶ Leniency bias reported included the subjectivity of evaluation and the lack of objective measures of competence. However, supervisors also noted leniency due to guilt or fear of damaging a student's career or training opportunities and difficulty providing negative feedback to students.⁶

Although supervisors indicate that they would disclose negative information in reference letters, those who receive such letters indicate that negative characteristics are rarely described.⁷ Furthermore, despite being described by some as more objective than self-reported curriculum vitae, reference letters suffer from low interrater reliability and low criterion-related validity.⁷ The increasingly frequent requirement for students to waive their rights to see their reference letters does, however, seem to have consequence, as letter writers tend to rate students less positively when the letter is identified as confidential.⁸ Those who read reference letters consider confidential ones to be more trustworthy. Despite this, legal precedent in Canada is variable regarding decisions to disclose or not disclose confidential reference letters to applicants to graduate programs or employment in university settings.^{9,10}

Development of standardized reference letter formats (as recommended in the 1960s) is one means by which the

profession is currently trying to address bias in letters. One prominent example is the Standardized Reference Form recently required by the Association of Psychology Postdoctoral and Internship Centers (APPIC) for psychology internship applications (www.appic.org). This form was initially developed by the Canadian Council of Professional Psychology Programs (CCPPP) and was intended to address problems of generally vague and overly positive reference letters. The standardized form requires the letter writer to comment on students' competencies across an array of areas. It explicitly requests that referees comment on students' areas for growth and development, which APPIC suggests encourages honesty from letter writers. While the use of a standardized reference form may offer some degree of transparency for students, unclear expectations for communication between students and referees about letter content is increasingly muddled by outside requirements for reference letters to be confidential and/or for students to waive their rights regarding liability of outcome.

Ethical guidance

Supervisors in psychology generally receive no training in the process or ethics of writing reference letters. Furthermore, the Canadian Psychological Association's *Canadian Code of Ethics for Psychologists, Fourth Edition* (herein referred to as the *Code*), does not specifically mention reference letters. However, the ethical principles and values of the *Code*, and their associated standards offer guidance. The following, in particular, are relevant (see the *Code* for the full standards):

- Principle I (Respect for the Dignity of Persons and Peoples): *General respect* (I.3), *Fair treatment/due process* (I.12, I.13), *Confidentiality* (I.45), and *Informed consent* (I.16, I.18, I.23, I.25, I.26)
- Principle II (Responsible Caring): *General caring* (II.1, II.2), *Competence and self-knowledge* (II.10), *Maximize benefit* (II.26), *Minimize harm* (II.30, II.32)
- Principle III (Integrity in Relationships): *Accuracy/honesty* (III.1), *Objectivity/lack of bias* (III.9), *Straightforwardness/openness* (III.13)
- Principle IV (Responsibility to Society): *Beneficial activities* (IV.4, IV.5, IV.10)

Recommendations for supervisors in psychology in the provision of reference letters

Drawing from the literature and the *Code*, I believe that the following recommendations would help to avoid some of the difficulties and dilemmas that occur in the provision of reference letters:

- Ensure that the student understands: (a) the purpose and nature of the letter (i.e., reference letter vs. letter of recommendation); (b) the mutual responsibilities of the supervisor and the student in preparing the reference letter; and (c) any expectations of confidentiality of the reference letter.
- Reference letters are summative and reflect evaluation, but are not evaluations in and of themselves. As such, letters should not include new information (positive or negative) that has not already been shared and discussed with the student.
- Only include information that is relevant for the stated or intended purposes of the specified letter.
- Avoid information and/or statements that could be (mis)construed as discriminatory in nature (including statements that are too circumstantial and/or vague and easily open to misinterpretation).
- Provide the letter no later than the agreed upon/stated due date.
- Decline to provide a reference letter if the above recommendations cannot be met.
- Revisit all of the above each time a new letter is requested by the student.

Challenges remain for students and referees alike given the requirement and continued heavy reliance on reference letters in the profession and the inherent power differential within this dependent relationship. It suggests the need for a culture shift to acknowledge areas of development as acceptable and normal in the profession. It is my hope that this brief article encourages greater dialogue and action regarding the ethical provision of reference letters. This includes efforts to evaluate the use of standardized reference letters, greater attention to training in the writing and reading of reference letters, agreement on examples of "good" reference letters, and supervision skills in the delivery of negative evaluative feedback and/or appropriately counseling students out of the profession.

Invitation: Please feel free to send your comments about this article or any ideas you have regarding topics for future Ethics Corner articles to ethicscttee@cpa.ca.

For a complete list of references, please go to www.cpa.ca/psynopsis

However, supervisors also noted leniency due to guilt or fear of damaging a student's career or training opportunities and difficulty providing negative feedback to students.

Défis éthiques liés

à la rédaction des lettres de recommandation des étudiants et stagiaires : conseils à l'intention des superviseurs en psychologie

Kathryn A. Birnie, Ph. D., C.Psych (pratique supervisée), boursière de recherches postdoctorales, Université de Toronto et The Hospital for Sick Children, et ancienne membre étudiante, Comité de déontologie de la SCP

Toute personne qui assume un rôle de supervision au sein de la profession de psychologue a à écrire des lettres de recommandation au nom des étudiants qui veulent être admis à une école d'études supérieures, cherchent un lieu d'internat ou veulent obtenir une bourse postdoctorale. Lorsqu'ils évaluent les candidats, les comités d'admission se basent en grande partie sur les lettres de recommandation; ainsi, les commentaires négatifs contenus dans la lettre de recommandation peuvent avoir une incidence énorme sur les perspectives d'avenir de l'étudiant^{1,2,3}. Contrairement à la lettre d'appui (p. ex., pour obtenir une subvention ou une bourse), la lettre de recommandation est censée être une évaluation du caractère et de la compétence du candidat, ou est perçue comme telle, et a une fonction de contrôle de l'accès à la profession.

Défis

Depuis longtemps, les psychologues trouvent difficile et frustrante la rédaction de lettres de recommandation. Dans les années 1960, l'*American Psychologist* a publié des commentaires recommandant l'élaboration de formulaires normalisés afin d'accroître l'efficacité de la rédaction des lettres de recommandation⁴. Les auteurs de ces commentaires soulignaient également que la possibilité de biais positifs, venant du fait que l'étudiant choisit lui-même l'auteur de sa lettre de recommandation, enlève de la pertinence aux lettres de recommandation pour les décideurs⁵.

Problème reconnu depuis longtemps, la majorité des lettres de recommandation sont en tous points positives et, de ce fait, peu informatives². Les superviseurs et les responsables de la formation estiment à 45 % à 53 % le taux d'erreur d'indulgence (c.-à-d. une évaluation plus positive qu'elle ne l'est en réalité) dans les lettres de recommandation des internes en psychologie, suivi par un taux d'erreur de tendance centrale (c.-à-d. résultats regroupés autour de la moyenne) de 32 % à 40 %, et, pour finir, un taux minime d'erreur de sévérité ou de complaisance excessive (c.-à-d. une évaluation plus négative qu'elle ne l'est en réalité) de

6 % à 9 %⁶. L'erreur d'indulgence déclarée se caractérisait par la subjectivité de l'évaluation et l'absence de mesures objectives de la compétence. L'indulgence relevée par les superviseurs dans les lettres de recommandation analysées était également le fait de la culpabilité, ou de la peur de nuire à la carrière de l'étudiant ou de le priver de possibilités de formation, ainsi que de la difficulté à donner aux étudiants une rétroaction négative⁶.

Bien que les superviseurs mentionnent qu'ils révéleraient, le cas échéant, des renseignements négatifs dans une lettre de recommandation, les personnes qui reçoivent les lettres déclarent qu'il est rare d'y lire des commentaires négatifs sur l'étudiant⁷. En outre, même si on considère les lettres de recommandation comme étant plus objectives qu'un curriculum vitae, elles présentent une faible fiabilité interévaluateurs et une faible validité critériée⁷. Le fait que les étudiants réclament de plus en plus le droit de voir la lettre de recommandation écrite à leur sujet semble avoir des conséquences; on constate en effet que les auteurs des lettres de recommandation ont tendance à noter les étudiants moins positivement lorsque la lettre de recommandation est identifiée comme étant confidentielle⁸. Les personnes qui lisent les lettres de recommandation estiment plus fiables celles qui sont confidentielles. Malgré cela, les décisions rendues au Canada en ce qui concerne la divulgation ou non de lettres de recommandation confidentielles au candidat qui fait une demande d'admission auprès d'un programme d'études supérieures ou une demande d'emploi à l'université⁹,¹⁰ varient.

L'élaboration de formulaires de lettre de recommandation normalisés (comme cela a été recommandé dans les années 1960) est l'un des moyens utilisés par la profession pour tenter d'éliminer la partialité dans les lettres. Le Standardized Reference Form exigé depuis peu par l'Association of Psychology Postdoctoral and Internship Centers (APPIC) pour les demandes de stages en psychologie (www.appic.org) en est un bon exemple. Créé au départ par le Conseil canadien des programmes de psychologie professionnelle (CCPPP), ce formulaire avait pour but de résoudre le problème des lettres de recommandation, généralement vagues et exagérément positives. Avec le formulaire normalisé, l'auteur de la lettre doit faire des observations sur les compétences de l'étudiant dans un

éventail de domaines. Il exige explicitement aux auteurs des lettres de recommandation de faire des commentaires sur les apprentissages à acquérir par l'étudiant et les compétences qu'il devrait perfectionner, ce qui, selon l'APPIC, incite à faire preuve d'honnêteté. Bien que le formulaire de lettre de recommandation normalisé offre un certain degré de transparence aux étudiants, les attentes, déjà imprécises, en ce qui a trait à la communication entre l'étudiant et l'auteur sur le contenu de la lettre deviennent encore plus floues, considérant qu'ailleurs, on exige que les lettres de recommandation soient confidentielles ou que les étudiants renoncent à leurs droits concernant la responsabilité des résultats.

Conseils d'ordre déontologique

Il est rare que les superviseurs en psychologie reçoivent de la formation sur le processus de rédaction des lettres de recommandation ou sur ses aspects éthiques. De plus, le *Code canadien de déontologie professionnelle des psychologues, quatrième édition* (ci-après appelé le *Code*) de la Société canadienne de psychologie ne mentionne pas expressément les lettres de recommandation. Cependant, les principes et les valeurs éthiques du *Code*, ainsi que les normes qui les accompagnent, fournissent une orientation. Les principes suivants sont particulièrement pertinents (pour consulter l'intégralité des normes, se reporter au *Code*) :

- Principe I (Respect de la dignité de la personne et des peuples) : *Respect général* (I.3), *Traitement équitable/procédures de recours* (I.12, I.13), *Confidentialité* (I.45) et *Consentement éclairé* (I.16, I.18, I.23, I.25, I.26)
- Principe II (Soins responsables) : *Soins généraux* (II.1, II.2), *Compétence et connaissance de soi* (II.10), *Maximiser les avantages* (II.26), *Minimiser les torts* (II.30, II.32)
- Principe III (Intégrité dans les relations) : *Précision/intégrité* (III.1), *Objectivité/impartialité* (III.9), *Droiture/ouverture d'esprit* (III.13)
- Principe IV (Responsabilité envers la société) : *Activités bénéfiques* (IV.4, IV.5, IV.10)

Recommandations à l'intention des superviseurs en psychologie sur la rédaction des lettres de recommandation

Sur la base de la documentation sur le sujet et du *Code*, les recommandations suivantes permettront, à mon avis, d'éviter certains problèmes et dilemmes associés à la production de lettres de recommandation.

- S'assurer que l'étudiant comprend : (A) le but et la nature de la lettre (c.-à-d. lettre de recommandation vs lettre d'appui); (b) les responsabilités mutuelles du superviseur et de l'étudiant dans la préparation de la lettre de

recommandation); c) les attentes par rapport à la confidentialité de la lettre de recommandation).

- La lettre de recommandation est une évaluation sommative et réfléchie, mais il ne s'agit pas d'une évaluation en soi. C'est pourquoi la lettre de recommandation ne doit pas comporter de l'information nouvelle (positive ou négative) qui n'a pas encore été partagée et examinée avec l'étudiant.
- L'auteur ne doit inclure que l'information pertinente compte tenu de l'objectif déclaré ou de l'objet de la lettre de recommandation en question.
- Éviter les commentaires ou les déclarations qui sont susceptibles d'être mal interprétés ou considérés comme étant discriminatoires (y compris les déclarations fondées sur des présomptions ou imprécises et susceptibles d'être mal interprétées).
- Fournir la lettre au plus tard à la date d'échéance indiquée ou convenue.
- Refuser de fournir une lettre de recommandation si les directives suggérées ci-dessus ne peuvent pas être suivies.
- Revoir l'ensemble des directives ci-dessus chaque fois qu'une nouvelle lettre est demandée par l'étudiant.

Mais la question des lettres de recommandation reste complexe, car, d'une part, elles sont exigées dans la profession et essentielles à la prise de décision, et d'autre part, elles créent forcément une relation de dépendance qui entraîne un déséquilibre des forces. Pour arriver à considérer les compétences à acquérir et à perfectionner comme étant acceptables et normales dans la profession, un changement de culture s'impose. J'espère que ce bref article stimulera le dialogue sur la production conforme à l'éthique des lettres de recommandation et sur les mesures à prendre en ce sens, à savoir s'efforcer d'évaluer l'utilisation des lettres de recommandation normalisées, prêter une attention particulière à la formation sur la rédaction et la lecture des lettres de recommandation, s'entendre sur des exemples de « bonnes » lettres de recommandation et définir les compétences dont ont besoin les superviseurs pour fournir des commentaires négatifs sur un étudiant ou conseiller les étudiants de l'extérieur de la profession.

Invitation : n'hésitez pas à envoyer vos commentaires sur le présent article ou à nous faire part de vos idées de thèmes pour les futurs articles de la rubrique « L'Espace éthique », en écrivant à ethicscttee@cpa.ca.



Rethinking Access to Psychotherapy

Louise Bradley, President and CEO, Mental Health Commission of Canada and Karen Cohen, CEO, Canadian Psychological Association

A sure recipe for failure is doing the same unsuccessful thing over and over, but expecting different results. With millions of Canadians reporting an unmet need for mental health care, it's time to revisit how we fund, deliver and access psychological services.

Imagine finding a lump in your breast, or blood in your urine. It's a terrifying prospect, and the visceral fear is tempered only by the knowledge that you can seek immediate medical attention.

Now, picture a scenario where your doctor takes note of your symptoms and tells you to return in six months, when she can determine if you've deteriorated sufficiently to warrant treatment.

We don't wait until cancer reaches stage four, or hold-off on treating diabetes until gangrene sets in. We intervene as quickly as possible, because it's not news that early detection is key to more successful health outcomes.

This doesn't only apply to physical illness. Ample evidence points towards the value – in both economic savings and improved patient outcomes – of mental health promotion and early intervention.

It's high time we turned the provision of mental health services on its head. Rather than offering people what we fund, we have to pause and ask ourselves what people actually need.

As provinces and territories are poised to receive an infusion of dollars targeted for mental health via the Health Accord, it's time to examine where new investments have the greatest potential to reinvigorate our uncoordinated patchwork of services.

We can't continue to funnel people to care providers unable or ill equipped to address their needs. Instead, we need to be asking: what do people need, where do they need it, and who should be providing it?

Right now, people are often only able to access mental health services when they are so critically ill they may be beyond help. This is because funded treatments are largely available through hospitals, where scant resources can't be expended on patients who aren't in critical distress. Additionally, primary care providers like family physicians and nurse practitioners often don't have the time, training or interest in treating mental health problems.



In an ideal world, people should be able to walk through the door of any trained health service provider and be assessed, diagnosed and appropriately triaged to the right kind of service and support. Instead, you have individuals and families pushed to the brink of despair, sitting on waitlists for mental health care. The repercussions of this unmet need reverberate throughout families, and across communities.

Sadly, our mental health system is, at best, designed to address mental health crises. What we need are appropriate provisions for helping healthy people stay well, and means to prevent moderately ill people from developing severe and persistent mental illness, which sometimes even hospital care cannot successfully treat.

Enhancing access to evidence-based psychological services has to be part of any well-thought out Canadian solution. Psychological treatments work. They are first line interventions for mental illness, particularly the ones experienced most commonly; anxiety and depression. Canada lags behind the United Kingdom and Australia, where governments have made publicly funded psychological services available.

Today in Canada, these psychological treatments are largely delivered by psychologists, specially trained social workers and psychotherapists; health providers whose services are not covered by our public health insurance systems.

While they can be accessed through private insurance, only higher earners, or those with private health insurance benefits through employment, can afford them. This leaves lower income Canadians, who report poorer mental health, unable to access effective treatment.

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Repenser l'accès à la psychothérapie



Louise Bradley, Présidente-directrice générale de la Commission de la santé mentale du Canada et Karen Cohen, Chef de direction de la Société canadienne de psychologie

La recette qui mène infailliblement à l'échec consiste à répéter la même chose en espérant des résultats différents. Lorsque les millions de personnes au Canada qui ont besoin de soins de santé mentale n'y ont pas accès, il est temps de revoir comment nous finançons, donnons et obtenons des services psychologiques.

Imaginez si vous trouviez une masse dans votre sein ou du sang dans votre urine. C'est une perspective effroyable et la peur viscérale qu'elle cause devient tolérable parce que vous savez que vous pouvez obtenir une attention médicale immédiate.

Imaginez maintenant que votre médecin note tous vos symptômes, mais qu'il vous dit de revenir dans six mois pour déterminer si votre état s'est suffisamment détérioré pour recevoir un traitement.

Nous n'attendons pas que le cancer atteigne le stade 4 ou que le diabète cause la gangrène avant d'intervenir. Nous agissons le plus rapidement possible parce que nous savons pertinemment que la détection précoce permet d'améliorer les résultats sur le plan de la santé.

Cela ne vaut pas seulement pour la santé physique. La valeur de la promotion de la santé mentale et de l'intervention précoce, tant pour la santé des patients que pour l'économie, a été amplement démontrée.

Il est grand temps de revoir du tout au tout la prestation des services de santé mentale. Au lieu d'offrir aux gens ce qui nous finançons, demandons-nous plutôt de quoi ils ont véritablement besoin.

Alors que les provinces et les territoires recevront de nouveaux dollars réservés à la santé mentale dans le cadre de l'accord sur la santé, il est temps d'examiner où les nouveaux investissements seront le plus susceptibles de revigorer nos services disparates.

Nous ne pouvons plus continuer à diriger les gens vers des fournisseurs de soins qui ne sont pas en mesure de répondre à leurs besoins ou qui n'ont pas les outils pour le faire. Nous devrions plutôt nous demander : de quoi ont-ils besoin, où en ont-ils besoin et qui devrait offrir ces services?

À l'heure actuelle, les gens ne sont souvent en mesure d'obtenir des services de santé mentale que lorsque leur état

s'est détérioré au point où ils sont pratiquement irrécupérables. Il en est ainsi parce que les traitements financés sont principalement offerts dans les hôpitaux, où les ressources limitées ne peuvent pas être consacrées aux patients qui ne sont pas dans un état critique. De plus, les fournisseurs de soins primaires comme les médecins de famille et les infirmières et infirmiers praticiens n'ont souvent pas le temps, la formation ni l'intérêt pour traiter les problèmes de santé mentale.

Dans un monde idéal, il serait possible d'aller voir n'importe quel professionnel de la santé pour être évalué et diagnostiqué pour ensuite recevoir le soutien et les services nécessaires. La réalité est tout autre, car des personnes et des familles sont poussées au désespoir en l'attente de recevoir des services de santé mentale. Les répercussions de ces besoins ignorés se font ressentir dans les familles et dans l'ensemble des communautés.

Notre système de santé mentale est conçu d'abord et avant tout pour répondre aux crises de santé mentale. Nous devons plutôt aider les gens sains à demeurer en bonne santé et ceux qui éprouvent des problèmes à ne pas développer des maladies graves et persistantes qui sont difficiles à traiter, même avec une hospitalisation.

L'amélioration de l'accès aux services psychologiques fondés sur des données probantes doit faire partie de toute solution réfléchie qui sera déployée au Canada. Les traitements psychologiques fonctionnent. Ils sont la première ligne d'intervention pour la maladie mentale, surtout pour les problèmes plus courants comme l'anxiété et la dépression. Le Canada accuse un certain retard par rapport au Royaume-Uni et à l'Australie, où les gouvernements offrent des services psychologiques publics.

De nos jours au Canada, les traitements psychologiques sont principalement offerts par les psychologues, les travailleurs sociaux ayant suivi une formation spéciale ainsi que les psychothérapeutes. Les régimes d'assurance publics ne couvrent pas les services offerts par ces professionnels.

Même s'il est possible d'y accéder par les régimes privés, seuls les gens qui ont un revenu élevé ou dont l'employeur offre une couverture d'assurance ont les moyens de le faire. Du coup, les personnes ayant un revenu inférieur, qui rapportent une moins bonne santé mentale, n'ont pas accès à des traitements efficaces.

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Psychotherapy

Continued from page 38

Often, professionals who work outside the public sector are painted as self-serving if they advocate for better access to their services. This assumption is as inherently flawed as suggesting that advocates of pharmacare are in cahoots with the drug industry.

Just as medication is effective for a range of health conditions, psychological treatments are effective for a range of mental health issues and disorders. Treatments that work should be accessible to those who need them. That is the Canadian way.

An archaic and outmoded system of care has excluded psychologists from contributing their vital services to the full scope of their capacity.

The Mental Health Commission of Canada together with the Canadian Psychological Association are among the many mental health stakeholders encouraging informed and meaningful debate about how psychological services can be best integrated into the public system.

Our efforts to date haven't been working. Our only hope of getting better results is to finally do something differently.

Psychothérapie

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Souvent, les professionnels qui travaillent dans le secteur privé sont perçus comme étant intéressés s'ils réclament un meilleur accès à leurs services. Cette supposition est fondamentalement fautive, car c'est comme si on suggérait que les défenseurs de l'assurance-médicament sont de connivence avec l'industrie pharmaceutique.

De la même façon que les médicaments permettent de traiter efficacement un grand éventail de maladies, les traitements psychologiques permettent de traiter différents problèmes et troubles associés à la santé mentale. Les traitements efficaces devraient être à la portée de tous ceux et celles qui en ont besoin. Cela cadre parfaitement avec les valeurs canadiennes.

Notre système archaïque et dépassé empêche les psychologues de prodiguer leurs services essentiels au meilleur de leurs capacités.

La Commission de la santé mentale du Canada et la Société canadienne de psychologie font partie des nombreux intervenants en santé mentale qui encouragent un débat éclairé et constructif sur la meilleure façon d'intégrer les services psychologiques au système public.

Jusqu'à maintenant, leurs efforts n'ont pas porté fruit. La seule façon d'obtenir de meilleurs résultats est de faire les choses différemment.



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Direct Billing to Insurers

Making Mental Health More Accessible

Sue Judge, Healthcare Technology Writer, TELUS Health

Just like any small business owner, in any market, psychologists in the private sector are responsible for all aspects of their practice, from sales and marketing, to office operations, and everything in between. And to build and manage a successful practice today requires technology. In addition to accounting and customer relationship management (CRM) software, direct-billing services are now making their way into clinics nationwide, quickly becoming essential to running an efficient practice, enhancing the patient experience and facilitating access to services.

Easing the pain of healthcare claims

Direct billing first gained popularity in pharmacies. We all likely take for granted that when we fill a prescription, we only pay for the amount not covered by our insurance plan. But, this wasn't always the case. We used to have to pay for the full amount of the prescription cost, and then fill out and submit our insurance claim paperwork for reimbursement. Today, virtually all pharmacies offer direct billing at the point-of-service. And now, psychologists can too.

At the end of a therapy session, patients typically expect to pay, get a receipt and eventually submit the claim paperwork to their insurance company, but times are changing. Just like pharmacists, psychologists can now electronically submit insurance claims on behalf of patients and get a real-time coverage response – right at the point-of-care. This means patients only pay for the amount not covered by their insurance plan and they don't have to submit paper claims after the service. It is all taken care of before ever leaving the clinic.

How does it work?

Leveraging modern cloud technology, today's direct billing solutions such as TELUS Health eClaims are typically free.

A few minutes to register online is all it takes to get up and running – there's no special hardware or software to purchase and install, there are no extra fees to use the service, and there's no extensive training to learn how to submit claims either. With an intuitive, easy-to-use interface, eClaims optimizes the claim process with real-time confirmation of patient coverage (when supported by the insurance company), resulting in faster payments and increased accuracy compared to the traditional paper submission process.

Psychologists who register for the eClaims service also

benefit from being listed on the TELUS Health website and various insurance company plan member portals. Potential patients use these sites to search for eClaims-enabled providers in their area. That's free marketing for eClaims-enabled psychologists!

Patients can commit to the recommended treatment plan

Since there is minimal up-front impact on out-of-pocket expenses, patients may be more inclined to keep their appointments and keep on their treatment course. This allows them to better stick to the recommended appointment schedule and to make progress in improving their symptoms.

The insurer's point of view

While they play an important role in Canada's social healthcare ecosystem, the fact remains that private insurers are motivated by cost management of plan sponsor benefit plans and must, therefore, consider bottom-line numbers. It is also true, however, that private insurers are competing for customers and need to differentiate their plans with value-added services, such as direct billing, that:

- increase automation;
- accelerate the processing and payment of claims;
- reduce call volume to customer service; and
- enhance plan member experience (and therefore plan loyalty).

Not all Canadian insurers offer direct billing as of yet, but it is quickly becoming the norm among most major health benefit plan providers.

The new debit card of healthcare

Direct billing is making it easier for people to access private healthcare services. Access to the right treatment, at the right time not only improves health outcomes, but also makes for a more efficient and focused workforce for employers.

Healthcare practitioners, like psychologists, who provide private sector services are quickly making up for lost time by leveraging technology to enhance patient experience and business operations. They understand that the financial benefits of direct billing services, the capabilities it affords, and the positive word-of-mouth it creates from happy patients are all well worth adapting to a new technology.

To learn more about TELUS Health eClaims, visit www.telushealth.com/eclaims-cpa.

McGill Psychology Student Association Presents: Psychology Research Case Competition



Kirsten Neprily, Undergraduate Student, McGill University

The McGill Psychology Student Association (MPSA) held its second annual Psychology Research Case Competition for undergraduate students at La Plaza. This year's expanded competition included participants from l'Université de Montréal and l'Université du Québec à Montréal in addition to those from McGill University and Concordia University. In all, 48 undergraduate students competed to develop the best research proposal.

The competition was founded in 2015 by the MPSA's Vice President Academic, Kirsten Neprily and Concordia's Undergraduate Psychology Association President, Samantha Briand to help students prepare for graduate studies. Though case competitions have long been a fixture in business education, this event is the first of its kind in the greater Montreal area.

The competition, which rests upon the philosophy that students should have the opportunity to take theory out of the classroom, provides competitors with an unsolved problem in the psychology literature and has them draft and present a research proposal. More broadly, the event provides competitors with the opportunity to network with faculty and researchers in psychology, collaborate with other students, think critically about psychology problems, and hone their presentation skills.

The competition was split into three categories (neuroscience, developmental and clinical), and each university provided one team of four participants per category. A week before the event, teams were given scientific articles to reference during the competition. After being greeted by organizers on the day of the event, participants were given 45 minutes to design their proposal. Next they gave a five minute presentation, followed by a question and answer period with the judges (Mélanie Béland, clinical doctoral student, Concordia University; Eva Alexandra Best, developmental doctoral student, l'Université de Montréal; and Fernanda Perez-Guay, post-doctoral student, l'Université du Québec à Montréal). Participants were given the opportunity to mingle and view student research poster presentations between each category competition. Following the competition, participants attended a networking cocktail event where the following winners were announced:

Neuroscience

Université de Montréal	Etienne Aumont Beatrice Marseille Veronique R. Dumont Elizabeth Jacob-Brassard
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Developmental

Concordia University	Arthi Rajadurai Laura Pareja Macine Iannuccilli Siri Cheemalavagupalli
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Clinical

McGill University	Valentine Clary Akira Wang Shona Mistry Sarah Wu
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The case competition was once again a great success. Next year, organizers hope to further grow the competition to a two-day event with more participating universities.

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Disability in Canada

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References, links and resources

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Défis éthiques liés à la rédaction des lettres de recommandation des étudiants et stagiaires : conseils à l'intention des superviseurs en psychologie

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